PROCEDURE WORKSHEET

(Physicians- Dictate Template Type)

USE PATIENT PLATE

University of California, Davis
Medical Center
Sacramento, California
UCD Pain Management Center
Follow-up Procedure Worksheet

Requesting Physician **Primary Care Physician (if not the same)**

_____ _____

Patient Information

_____ Age ____ Sex: M ☐F☐
Last Name First M.I.

ABOUT YOUR PAIN (Chief Complaint)
What is the main problem for which you are seeking treatment at the Pain Management Center?

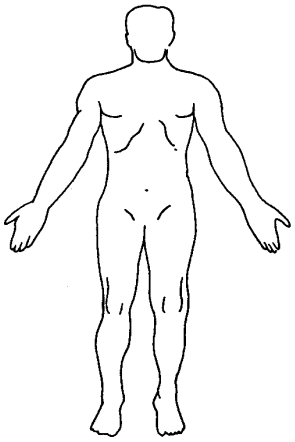
_____

_____

_____

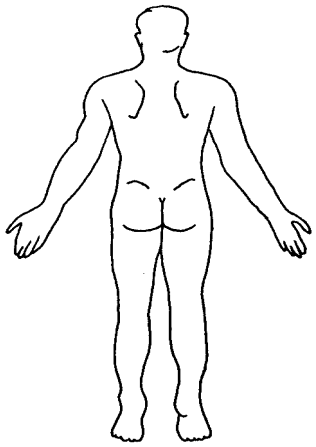
PAIN LOCATION

Right



Front

Left



Back

Right

Please mark the location(s) of your pain on the diagrams above with an "X." If whole areas are painful, please shade in the painful area.

ONSET OF PAIN and DURATION

When did your current pain start? _____

Briefly describe how your current pain started? _____

_____

_____

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PAIN QUALITY

How would you describe the pain (choose as many adjectives as are applicable)?

☐burning	☐sharp	☐cutting	☐throbbing
☐cramping	☐numbness	☐dull, aching	☐pressure
☐pins and needles	☐shooting	☐electric-like	☐other

RATE YOUR PAIN INTENSITY

If the number 0 is "no pain" and the number 10 is the "worst pain imaginable", what number describes your pain **RIGHT NOW –** (circle a number below)

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Imaginable

Please circle the one number that best describes your average pain for the last week.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Imaginable

PRIOR INJECTIONS OR PROCEDURES

Name of procedure performed on your last visit _____None ☐

If yes, did you notice any relief? No ☐ Yes ☐

If yes, what percent relief did you notice?_____ % For how long? _____

Were there side effects? Explain:

_____

Have you had an **infection**, **fever, or chills** in the last 7 days? No ☐ Yes ☐

Have you taken **antibiotics** in the last 7 days? No ☐ Yes ☐

Have you or any blood relative had a **Problem with Anesthesia/Sedation in the past**? No ☐ Yes ☐
If yes, describe.

_____

How many hours has it been since you **last** had any **solid food** _____hrs. or **clear liquids**_____hrs.

Do you have a history of ☐**stridor,** ☐**snoring, or** ☐**sleep apnea**?
*If **Yes**, check the appropriate box and describe.*

_____

Female Patients: Is there any possibility that you could be pregnant? No ☐ Yes ☐

CURRENT MEDICATIONS: Patients will be a given current medication sheet to fill out or update. If you have not received a current medication sheet, please request one at the front desk of the clinic.

Please list any **Blood Thinning** or **Clot Preventing Medications** (like Coumadin, Plavix, Aspirin, Motrin, Naprosyn, Daypro, Ticlid, etc.) that you have taken in the last 7 days

1	2
3	4