UF UNIVERSITY of FLORIDA

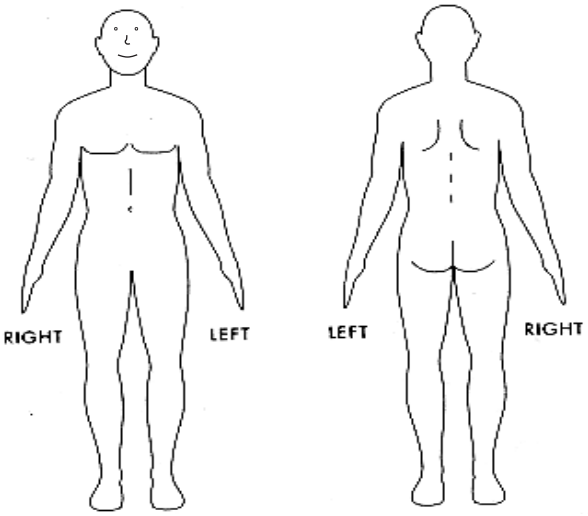
Pain Medicine Clinic

Please complete the attached questionnaire before your appointment. It is confidential and will be part of your medical record. It asks for information about your current problems and your past medical history. This form will give your doctor a better understanding of your problem, and will allow him or her to spend more time discussing treatment plans with you.

FOLLOW-UP VISIT INFORMATION

Name: _____ Phone #_____ Date of Birth _____

Front **Back**



What are your activity goals for your pain treatment?

1) _____

2) _____

3) _____

CHANGES IN YOUR PAIN SINCE LAST VISIT:

_____

_____

_____

_____

_____

Please shade in the areas where you feel pain.
Put an X on the area that hurts the most.

WHICH WORDS DESCRIBE the QUALITY of your pain:

1.	Throbbing	5.	Cold freezing	8.	Shooting
2.	Cramping	6.	Hot-burning	9.	Stabbing
3.	Heavy/pressure	7.	Electric-shock	10.	Itching
4.	Tingling/pins & needles			11.	Numbness

Please circle all ACTIVITIES that MAKE YOUR PAIN WORSE: rest touch sitting standing bending lifting walking light exercise sex warm compresses cold compresses relaxation techniques Other:_____

Please circle all ACTIVITIES that MAKE YOUR PAIN BETTER: rest touch sitting standing bending lifting walking light exercise sex warm compresses cold compresses relaxation techniques Other:_____

Please circle: RELIEF (%) YOU HAVE HAD IN THE LAST 24 HOURS from medications & treatments**:**

No Relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete Relief

WHEN YOU TAKE YOUR MEDICATION, how many HOURS OF RELIEF do you get?

_____ hours No help at all. I do not take pain medications

Does your pain affect your sleep? YES NO **Does your pain cause depression? YES NO**

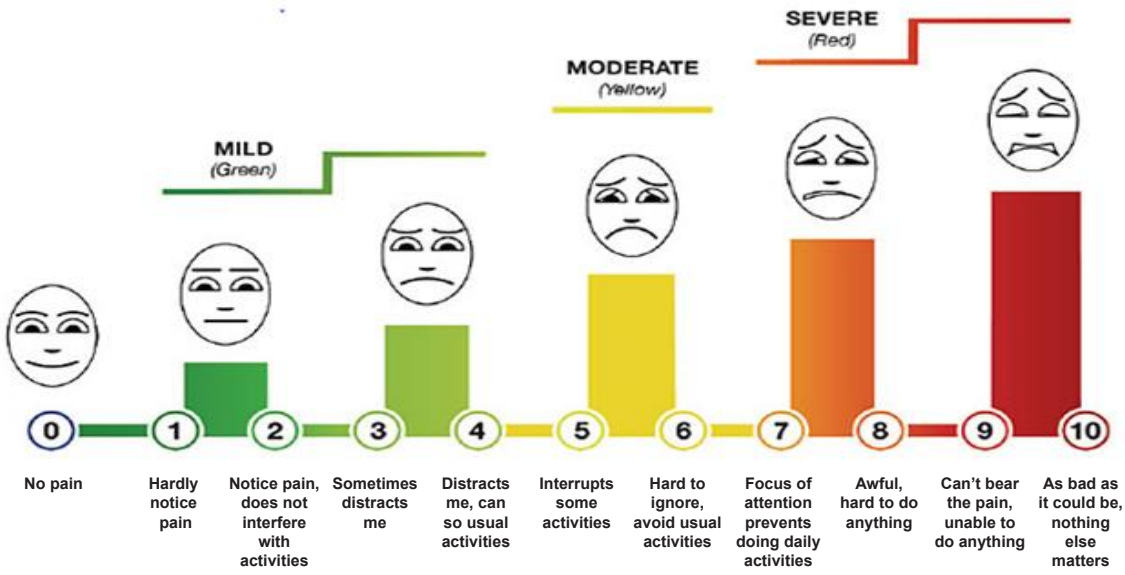
Does your pain cause anxiety? YES NO

Changes in home, family, or social situations_____

Sources of enjoyment &/or support (family, friends, hobbies)**?**_____

Sources of stress (family, finances, etc.)? _____

Changes in daytime activities_____



Please circle the number that indicates your **WORST PAIN LEVEL over the last week:**

No pain 0 1 2 3 4 5 6 7 8 9 10 **WORST** you can imagine

Please circle the number that indicates your **LEAST PAIN LEVEL over the last week:**

No pain 0 1 2 3 4 5 6 7 8 9 10 **WORST** you can imagine

Please circle the number that indicates your **AVERAGE PAIN LEVEL over the last week:**

No pain 0 1 2 3 4 5 6 7 8 9 10 **WORST** you can imagine

Please circle the number that indicates your **CURRENT PAIN LEVEL – RIGHT NOW:**

No pain 0 1 2 3 4 5 6 7 8 9 10 **WORST** you can imagine

Please help us understand **HOW PAIN HAS INTERFERED WITH your:**

A. General Activity
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

B. **Mood**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

C. **Walking Ability**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

D. **Ability to perform tasks at home or at work:**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

E. **Relations with other people**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

F. **Sleep**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

G. **Enjoyment of life**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 **completely interferes**

Other Symptoms: please circle those you've had SINCE LAST CLINIC VISIT:

General:
- fever
- chills
- weight loss
- weight gain
- fatigue
- weakness
- sweating

Skin:
- rash
- itching

Head, Ears, Nose, Throat:
- headache
- hearing change
- ears ringing
- ear pain
- ear drainage
- nosebleeds
- congestion

Eyes:
- blurred vision
- double vision
- sensitivity to light
- eye pain
- eye drainage
- eye redness

Cardiovascular:
- chest pain
- rapid heartbeat
- irregular heartbeat
- lying down→ short of breath
- leg swelling

Respiratory:
- cough
- productive cough
- coughing blood
- short of breath w/ exertion
- wheezing

Gastrointestinal:
- heartburn
- nausea
- vomiting
- abdominal pain
- diarrhea
- constipation
- blood in stool
- black stool

Urinary:
- pain
- urgency
- frequency
- urinary incontinence
- blood in urine
- flank pain
- pelvic pain

Musculoskeletal:
- muscle aches
- low back pain
- neck pain
- joint pain
- falls

Bleeding / Allergic:
- bruise easily
- bleeding easily
- environmental allergies
- increased thirst

Neurologic:
- dizziness
- tremor
- change in sensation
- change in speech
- focal weakness
- changes alertness

Psych:
- depression
- suicidal thoughts
- hallucinations
- nervous / anxious
- irritability
- memory problems
- sleep _____/24 hr
- difficult falling asleep
- difficult staying asleep

PLEASE TELL US ABOUT ANY MEDICATION CHANGES SINCE LAST VISIT, INCLUDING:

1) **NEW MEDICATIONS,**
2) **DISCONTINUED MEDICATIONS,**
3) **RUNNING OUT OF MEDICATION,**
4) **STOPPED TAKING A MEDICATION,**

ALSO: PLEASE TELL US ABOUT ANY MEDICATION SIDE EFFECTS THAT YOU ARE CONCERNED ABOUT:

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