IPS INTERVENTIONAL PAIN SPECIALISTS

Your Name: _____
Chief Complaint: _____
Provider: Reyes / Fuke / Lin / Pinchot / Uzodinma/ Redko
Hatmaker / Dieter / Gonzalez / Brown/ Niekamp
Preferred Pharmacy_____

Describe any changes since your last office visit? _____

If you had a procedure, what did you have done and percentage improvement? _____

How would you describe your pain? (**CIRCLE all that applies**) burning, shooting, aching, stabbing, sharp, dull, throbbing, cramping, crushing, vague, tingling, stiff, tight, heavy, sore, nagging, pins and needles.

Do you have any accompanying symptoms? (**CIRCLE all that applies**) weakness, spasms, numbness, swelling, headaches, hot, cold, other: _____

Rate your pain **RIGHT NOW** ..... 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Rate your pain at its **BEST** (least pain)..... 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Rate your pain at its **WORST** (most pain)..... 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When was the last time you **FILLED** your pain medications? _____
When was the last time you **USED/TOOK** your pain medications? _____
Do you have any side effects with your current pain medications? _____

Review of Systems (**CIRCLE all that applies**)
General: weight gain, weight loss, fever, chills, fatigue
HEENT: headache, ringing in ears, hearing loss, sore throat, difficulty swallowing, vision changes
Chest: difficulty breathing, cough, bloody or colored sputum
Heart: chest pain, slow heart rate, fast heart rate, high blood pressure, low blood pressure
GI: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stool
Musculoskeletal: muscle pain, joint pain, back pain, neck pain
Neurology: seizures, dizziness, falling, loss of bladder control, loss of bowel control
Psychiatric: depression, anxiety, panic attack, suicidal thoughts
Male/Female: decreased sexual drive, impotence, erectile dysfunction
Blood: low blood count, easy bruising, easy bleeding, history of blood transfusion
Skin: rash, itching, color changes

Medical History: Please list any **NEW** medical problems since your last clinic visit
_____
Surgical History: Please list any **NEW** surgeries since you last clinic visit
_____
Psychiatric History: Please list any **NEW** changes since your last visit
_____
Allergies: Please list any **NEW** allergies since your last clinic visit
_____
Medications: Please list any **NEW** medications (non-pain medication) since your last clinic visit:
_____

OFFICE USE

Last Consent: Last UDS: Last LFT/BUN/Cr: Last EKG: Last MMT: Last CC: