portland PAIN CARE | Joseph P. Stapleton, MD

Your completed paperwork helps our physicians & other providers get to know you & your medical history better. We rely on accuracy & completeness to provide you with the best possible care.

Medication Management Follow-Up Form

Patient Information

Name: ______________________ Date: ______________________

Referring Physician: ______________________ Primary Care Provider: ______________________

Height: ____________ Weight: ____________

Current Medications/Allergies:

Medications: ☐ Currently not taking any medications (Please include dosage and how often you take your medication).

______________________ ______________________

______________________ ______________________

______________________ ______________________

Do you currently take any blood thinning medication (Aspirin, Coumadin, Warfarin, Plavix, Lovonox)? ☐ Yes ☐ No If Yes, when was your last dose? ______________________

Allergies: ☐ I have No Known Drug Allergies

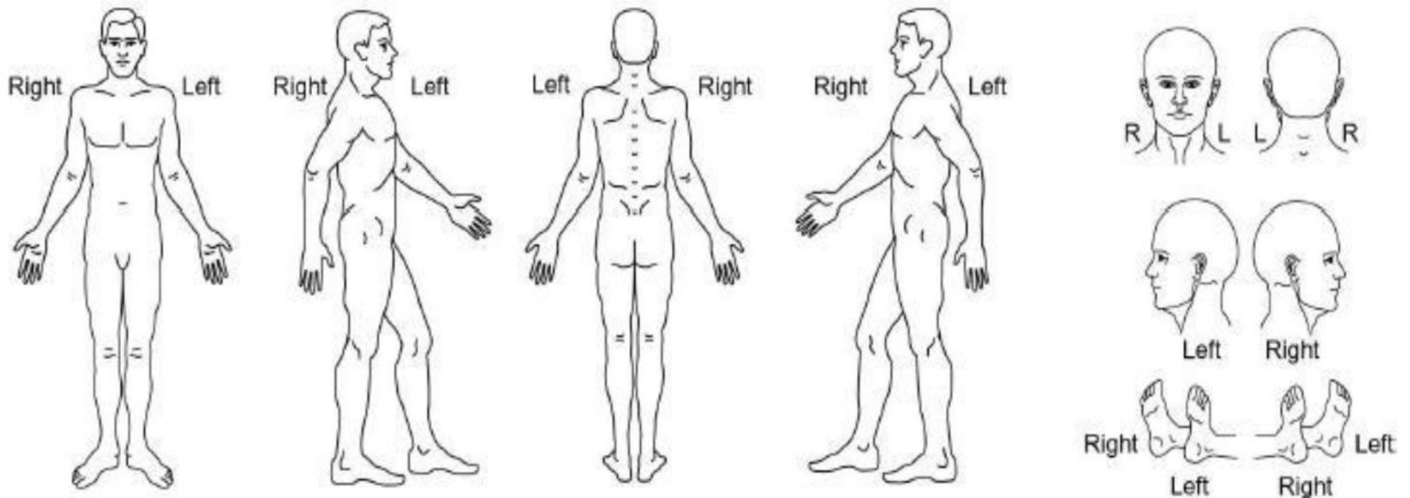
______________________ ______________________

______________________ ______________________

Pain History

Chief Compliant: (Reason for your visit today?) ______________________

Use diagram to indicate the area of your pain. Mark location(s) with an 'X'



Pain Intensity (0 being no pain, 10 being worst pain) C**ircle** number that best describes your pain.

***Please circle only one number**

Average Pain	0	1	2	3	4	5	6	7	8	9	10
Worse Pain	0	1	2	3	4	5	6	7	8	9	10
With Activity	0	1	2	3	4	5	6	7	8	9	10
Current Pain	0	1	2	3	4	5	6	7	8	9	10
With Meds	0	1	2	3	4	5	6	7	8	9	10
Without Meds	0	1	2	3	4	5	6	7	8	9	10

Pain History Continued...

Activities that make pain worse:

- ☐ NONE
- ☐ Bending forward
- ☐ Exertion/Exercise
- ☐ Getting out of chair
- ☐ Lifting
- ☐ Lying down
- ☐ Moderate physical activity
- ☐ Nonspecific activity
- ☐ Position change
- ☐ Reaching
- ☐ Significant physical activity
- ☐ Sitting
- ☐ Standing
- ☐ Turning the head
- ☐ Twisting
- ☐ Walking

Activities that make pain better:

- ☐ NONE
- ☐ Bending forward
- ☐ Injections
- ☐ Lying down
- ☐ Medications
- ☐ Moving
- ☐ Position change
- ☐ Physical activity
- ☐ Procedures
- ☐ Rest
- ☐ Sitting
- ☐ Standing

Qualities of your pain:

- ☐ NONE
- ☐ Aching
- ☐ Burning
- ☐ Dull
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Throbbing
- ☐ Pressure
- ☐ Crushing
- ☐ Cramping
- ☐ Spasmodic
- ☐ Pulling
- ☐ Tender
- ☐ Tight
- ☐ Knife like
- ☐ Hot
- ☐ Sore

Duration of your pain ***Please check only one**

☐ No pain ☐ Constant pain ☐ Intermittent pain

Post Procedure Assessment (if applicable)

What percentage of improvement did you get from your last procedure/treatment? ______________________

How long did it last? ______________________

Review of Systems

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Poor appetite
- ☐ Poor sleep
- ☐ Weight gain
- ☐ Weight loss

- ☐ Hearing loss
- ☐ Sore throat
- ☐ Blurred vision
- ☐ Decreased vision

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough

- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Swelling in legs

- ☐ Rash
- ☐ Itching
- ☐ Lesions
- ☐ Bruise easily

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Stiffness
- ☐ Weakness

- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Loss of bowel/bladder
- ☐ Heartburn
- ☐ Constipation

- ☐ Sexual problems
- ☐ Problems urinating

- ☐ Headache
- ☐ Dizziness
- ☐ Loss of consciousness
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling

- ☐ Depression
- ☐ Anxiety

Medication Assessment

Choose the number that describes how, during the past 2 weeks, pain has interfered with your:
(0 being no pain, 10 being worst pain) ***Please circle only one number**

General activity	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of life	0	1	2	3	4	5	6	7	8	9	10
Falling asleep	0	1	2	3	4	5	6	7	8	9	10
Staying asleep	0	1	2	3	4	5	6	7	8	9	10

Medication Assessment Continued...

Your chronic pain may limit activities that are important to you (e.g. working, golfing, walking, child care). Please list one important activity that is difficult for you to perform so that we can monitor it during your pain treatment. ____________________

How would you rate the difficulty you have had doing this activity over the past 2 weeks? (0 representing no difficulty).   0 1 2 3 4 5 6 7 8 9 10

Over the past 2 weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious, or on edge:

☐ Not at all ☐ Several ☐ More ☐ Nearly everyday

Feeling down, depressed, or hopeless?

☐ Not at all ☐ Several ☐ More ☐ Nearly everyday

Little interest or pleasure in doing things?

☐ Not at all ☐ Several ☐ More ☐ Nearly everyday

Please pick the number that best shows the severity of the worst side effect of your pain medication. ? (0 representing no severity).   0 1 2 3 4 5 6 7 8 9 10

In the past 2 weeks, how many days have you had where you felt that you needed to take more pain medication then you provider is currently prescribing?   0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

Please rate how satisfied you are with the results of your pain treatment. (0 Representing no satisfaction, 10 Representing satisfaction).   0 1 2 3 4 5 6 7 8 9 10