portland PAIN CARE | Joseph P. Stapleton, MD

Follow Up Form

Patient Information

Name: _____ **Date:** _____

Referring Physician: _____ **Primary Physician:** _____

Current Medications

Medications: ☐ **No changes since last visit.**

Please list any changes in your medications since your last visit.

_____ _____

Do you currently take any blood thinning medication (Aspirin, Coumadin, Warfarin, Plavix, Lovenox)? ☐ **Yes** ☐ **No** **If Yes, when was our last dose?** _____

Immunizations

Have you had a flu shot this season? ☐ **Yes** ☐ **No**

Have you ever had a pneumonia immunization? ☐ **Yes** ☐ **No**

Allergies

Please list all allergies: ☐ **I have No Known Allergies**

_____

Pain History

Chief Complaint: Reason for your visit today? _____

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