FLORIDA MEDICAL PAIN MANAGEMENT

FOLLOW-UP VISIT EVALUATION

Patient Name: _____ **Date:** _____

Has your insurance changed? □Yes □No (Please give your new insurance card to the receptionist)

Have you seen a new doctor, been in the hospital or changed Primary Care Physicians since your last visit? □Yes □No

Have you had any new injuries since your last visit? (Auto/Work Comp) □Yes □No

Are you pregnant at this moment or do you have any plans of becoming pregnant? □Yes □No □NA (If you are male)

If you are over the age of 50, have you received a flu shot since September of last year? □Yes □No □NA(If you are not yet 50)

If you are over the age of 65, have you had a pneumococcal vaccination in your lifetime? □Yes □No □NA(If you are not yet 65)

1. On average, how severe was the pain this last week? 1=Minor pain 5=Moderate 10=Unimaginable, unspeakable	1	2	3	4	5	6	7	8	9	10
2. How many hours did you work: Last week?	The week before?									
What activities at home or work are difficult for you because of pain? (Example: sitting, standing, walking, reaching, etc.)										
#1	#2	#3								
Describe any change in these 3 activities since the last medical visit. Be specific (Example: "Can walk 8 blocks now. The last time I saw Dr. Smith, could only walk one block.")										
Activity 1-										
Activity 2-										
Activity 3-										

YOUR PAIN CONTROL (OK OR NOT OK; WITH PAIN MEDICINE, IF ANY)		
Is pain level OK MOST of the time?	□Yes	□No
Is pain level OK when you are inactive/resting/relaxed?	□Yes	□No
Is pain level OK when you get up in the morning?	□Yes	□No
Is pain level OK when you try to sleep?	□Yes	□No
Do you have any new pain since your last visit?	□Yes	□No

Current Pharmacy Location & Phone

_____

_____

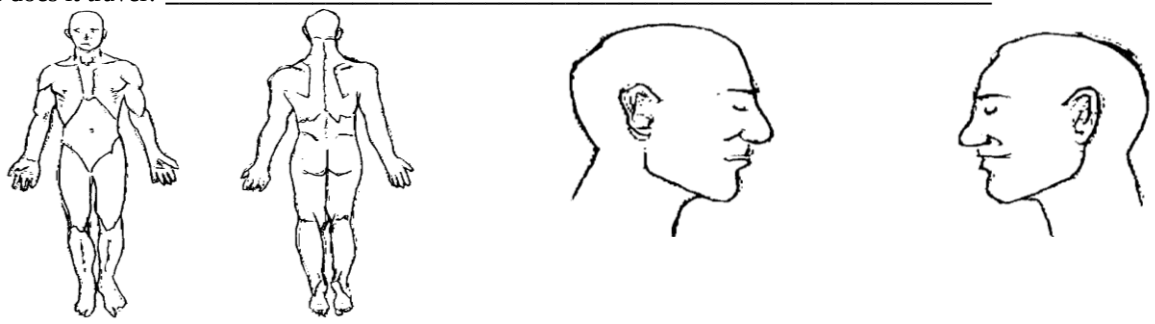
_____

Answer below if you are currently prescribed medications. □NA			
QUESTIONS ABOUT YOUR MEDICINE USE AND ITS EFFECT ON YOU			
Do you take all your medicine as directed on the bottle?	□Yes	□No	
Does your medication make you feel worse in any way?	□Yes	□No	
Do you have concerns about the medication you are taking?	□Yes	□No	
□ No changes in medications since last visit.			
Please list any NEW medications since last visit including over the counter drugs. (may attach medication list)			
1.	2.	3.	4. 5.

Have you had Physical Therapy:	**□ No**	**□Yes**	**If yes, for how long?**	**Was it helpful?**
What other things have you tried to relieve your pain? (such as heat, cold, relaxation, or stretching?)				

Where does it hurt? Mark the body drawing to show where it hurts. Does the pain move from one place to another? Yes □ No □

Where does it travel? _____



YOUR PROGRESS TOWARD GOALS FOR PAIN MANAGEMENT		
Have you reached your pain relief goal?	□ **Yes**	□ **No**
Are you closer to pain relief goal now than 6 months ago?	□ **Yes**	□ **No**
What can YOU do to improve your physical function?		
What do you still want to be able to do within reason?		

To save time in the future, please fill out this form online before your next visit at https://fmpm.portalforpatients.com