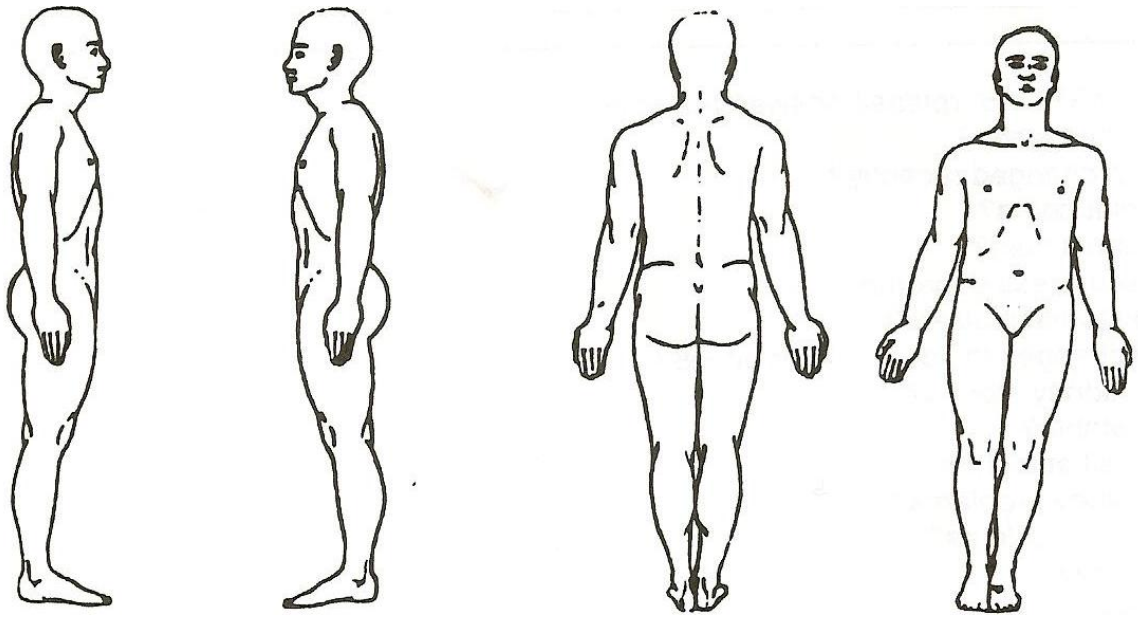
FOLLOW UP VISIT

Exam Room # _____

Name		**DOB**		**MRN**		**Service Date**	
Accompanied by:		**Pharmacy / Location**					
Chief Complaint / Reason for Visit							

Current pain score (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe) **Worst** pain score (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

PLEASE SHADE IN THE LOCATION OF YOUR PAIN.



Has your pain changed since your last visit? □ No Change □ Improved □ Worsened

What percentage has your pain improved or worsened? □ 0% □ 25% □ 50% □ 75% □ 100 % □ other___

Response to the last intervention (i.e. meds, side effects, procedures, surgery, physical therapy)?

_____

PLEASE REVIEW MEDICATION LIST. Any changes since last visit? □ yes □ no

Cross out medications you are no longer taking and write-in medications including dosage not currently listed.

Do you need refills on medications previously prescribed by Dr. Nguyen or Dr. Lin? □ yes □ no

(If so, please circle the medication on your medication list)

Review of systems

Changes to urine or bowel? □ yes □ no

New weakness? □ yes □ no

Constipation? □ yes □ no

Weight? □ gaining □ losing □ stable

If weight change, is it intentional? □ yes □ no

Medical Problems

Any changes since last visit? □ yes □ no

If yes, what are the changes? _____

_____

Surgical History

New surgery since last visit? □ yes □ no

If yes, please list. _____

Social History (i.e. smoking, drinking, work)

Any changes since last visit? □ yes □ no

If yes, what are the changes? _____

Do you smoke? □ yes □ no

Family History (i.e. diseases)

Any changes since last visit? □ yes □ no

If yes, what are the changes? _____