Suncoast Medical Clinic

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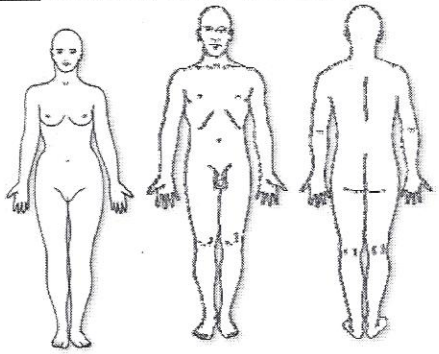
FOLLOW UP VISIT

NAME: _____ Pulse _____ BP _____Ht_____Wt_____ BMI_____ (Age 65+ ≥30 or ≤22)
(Age 18-64 ≥25 or ≤18.5)

What is your main problem/chief complaint today? _____

PAIN LOCATION/ PAIN RADIATION: Please **mark the location**(s) of your pain **with an "X" or circle the areas**. If pain travels, **draw an arrow** indicating where pain starts and ends.



PAIN QUALITY: (please circle) Burning Cramping Sharp Dull / aching Throbbing

SEVERITY OF PAIN: (please circle) Mild Moderate Severe

Pain Scale: (0 being no pain/ 10 severe pain) 0 1 2 3 4 5 6 7 8 9 10

ASSOCIATED SYMPTOMS: (please circle) Numbness/Tingling Weakness Muscle spasm Stiffness

PAIN FREQUENCY: (please circle) Constant pain (all the time) Intermittent pain (comes & goes)

SYMPTOM PROGRESSION: (please circle) Stable Worse Improved Unchanged

PAIN BETTER WITH: (please circle items that apply)

Rest	Massage	Sitting	Medications
Heat	Elevation	Standing	Lying down
Ice	Stretching	Walking	Other _____

PAIN WORSE WITH: (please circle items that apply)

Bending forward	Walking	Lifting
Bending backward	Standing	Twisting
Weight bearing	Sitting	Other _____

REVIEW OF SYSTEMS (ROS): (please circle all that apply since your last visit)

Fatigue	Constipation	Swelling in the feet
Fever /Chills	Diarrhea	Dizziness
Excessive sweating	Loss of bowel control	Anxiety/ depression
Unintentional weight gain	Loss of bladder control	Memory loss
Unintentional weight loss	Nausea/vomiting	Difficulty sleeping
Abdominal pain	Fluttering of the heart	Itchiness/Hives

RECENT INJECTION: __Yes__ No How much relief did you get? _____% How long did relief last? ____

Do you smoke or chew tobacco? ____Yes ___ No How much? _____
Do you drink alcohol? ____Yes ___ No How much? _____
Do you have history of Arthritis? ____Yes ___ No Which joints? _____

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