

Return Patient Visit Form

Patient Name _____

A. Reason for your visit today:
 Medication refill
 Follow up after a procedure
 Routine follow-up
 Other, please explain _____

<i>Office Use Only</i>	
Blood Pressure:	_____
Heart Rate:	_____
Temperature:	_____
Weight:	_____

B. Area(s) of Pain _____

C. Has your pain changed since the last visit: Yes No

D. Nature of Pain: Constant Intermittent

Intensity of Pain: On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain; how would you rate your pain?

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse?

Bending Lifting Coughing Sneezing Defecation Prolonged Sitting
 Prolonged Standing Walking Other, please explain _____

What makes your pain better?

Rest Activity/physical therapy Massage Heat Cold
 Lying in a fetal position Lying on your back Medication
 Other, please explain _____

E. Have you had any new medical problems or hospitalizations since your last clinic visit? Yes No
 If yes, please explain: _____

F. Have you started any new medication(s) not prescribed by my office since the last clinic visit? Yes No
 If yes, please list the name(s) and dose(s) of the medication(s): _____

G. Have you noticed any side effects from medications: Yes No
 If yes, please explain: _____

H. Have you had any of the following since the last visit:

- | | | |
|----------------------|------------------------------|-----------------------------|
| 1. Nausea/Vomiting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Constipation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Urinary retention | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Flu-like symptoms | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

I. Any use of tobacco? Current Smoker Former Smoker Nonsmoker
 If yes, how many PPD? _____

J. Primary care doctor? _____