US Pain & Spine Institute™

Follow Up

Date of visit: _____

Name: _____

Date of birth: _____

Pain Description

Where is your **worst** pain today (chief compliant)?

_____

Does the pain radiate? Where? _____

Is this pain new? ☐ Yes ☐ No

Since your last office visit, has the pain

☐ Stayed the same ☐ Increased ☐ Decreased

Has the pain changed in character? ☐ Yes ☐ No

If yes, please describe: _____

_____

Have you developed any new:

☐ Balance problems ☐ Bladder incontinence

☐ Bowel incontinence ☐ Chills ☐ Fever

☐ Difficulty walking ☐ Nausea ☐ Vomiting

☐ Tingling Where: _____

☐ Numbness Where: _____

☐ Weakness Where: _____

Did you have a procedure? ☐ Yes ☐ No

Did it help? ☐ Yes ☐ No Please explain:

_____

Percent of improvement in pain (0-100%) _____

Any problems with procedure? _____

Are you getting relief from your current medications? ☐ Yes ☐ No

Percent of improvement in pain (0-100%) _____

If no, please explain: _____

Mark medication side effects, if any.

☐ Drowsiness ☐ Itching ☐ Dry mouth

☐ Nausea ☐ Vomiting ☐ Constipation

☐ Dizziness ☐ Confusion ☐ Weight gain

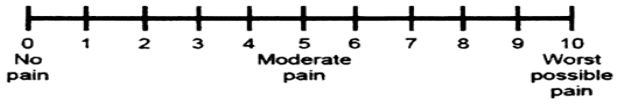
☐ I do not have any side effects with medications.

Is there anything else we can help you with today?

_____

_____

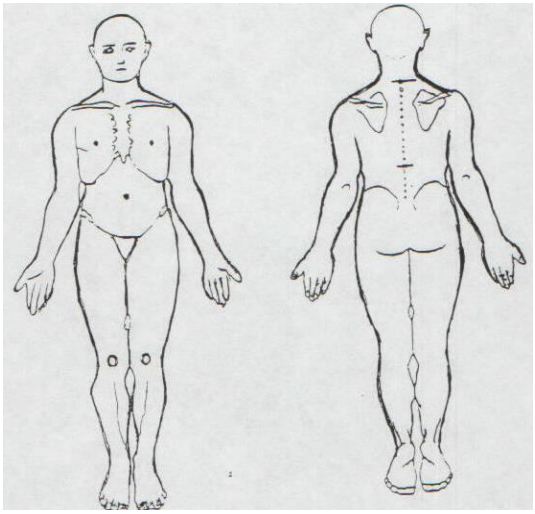
PAIN SCALE Over the last month, rate your pain:



Right Now: ____ Worst: _____ Acceptable Level: ____

With medications: ____ Without medications: ____

Mark pain on diagram. Mark worst spot with an X.



Office Use Only: No Low Mod High

MODI: _____ / _____ = _____

Ht: _____ Wt: _____ Pulse: _____

O2: _____ BP: _____ / _____

LMP: _____ /_____ /_____

UA POC: Not required I E GENE Done

BZO BAR COC THC MET OPI MTD TCA OXY PCP AMP

PMP: Checked _____ /_____ /_____ Pos Neg

Medical History – Changes since your last office visit

New Surgeries / Hospitalizations ☐ Yes ☐ No
New medications ☐ Yes ☐ No
New medical problems ☐ Yes ☐ No
New imaging studies ☐ Yes ☐ No
If yes, elaborate: _____
Currently prescribed a blood thinner? ☐ Yes ☐ No Prescriber: _____
Allergies: ☐ No known allergies ☐ Latex ☐ Medications (list all) _____

Review of Systems

General
☐ Weight Gain / Loss
☐ Tiredness
☐ Fever ☐ Chills
☐ Night Sweats

Skin
☐ Rash
☐ Itching

HEENT
☐ Dry Mouth
☐ Head Injury

Neck
☐ Neck Pain
☐ Neck Stiffness
☐ Neck Mass

Respiratory / Cardiovascular
☐ Difficulty Breathing
☐ Abnormal Blood Pressure
☐ Palpitations / Chest Pain

Gastrointestinal
☐ Last Bowel Movement
Date: _____
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Abdominal Pain
☐ Incontinence of Stool

Genitourinary
☐ Pelvic Pain
☐ Incontinence of Urine

Musculoskeletal
☐ Back Pain
☐ Decreased Range of Motion
☐ Joint Pain
☐ Joint Redness / Swelling
☐ Muscle Atrophy
☐ Muscle Cramps
☐ Muscle Pain
☐ Muscle Weakness
☐ Swelling of Extremities

Neurological
☐ Headaches
☐ Dizziness
☐ Weakness
☐ Numbness
☐ Tingling
☐ Seizures
☐ History of Stroke

Psychiatric
☐ Depression
☐ Suicidal Ideation
☐ Homicidal Ideation
☐ Anxiety
☐ Insomnia
☐ Impaired Cognitive Function

Hematology
☐ Abnormal bleeding
☐ Blood clots

Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow # Children: _____
Occupation: _____ ☐ Student ☐ Unemployed ☐ Retired ☐ Disabled
Smoking: ☐ Never a smoker ☐ Former smoker ☐ Current some day smoker ☐ Current every day smoker
Alcohol use: ☐ Never drinks ☐ Socially ☐ History of Alcoholism ☐ Current Alcoholism
Illegal drug use: ☐ YES ☐ NO ☐ Formerly used illegal drugs If yes, please elaborate: _____
Have you ever abused prescription medications: ☐ YES ☐ NO If yes, please elaborate: _____

Pharmacy Information

Pharmacy Name: _____ Phone Number: _____
Address: _____
Patient signature: _____ Date: _____

SOAPP® Version 1.0 - SF

Name: _____ Date: _____

The following are some questions given to all patients at USPS Medical Associates, P.L.L.C. who are taking or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:
0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very Often

1. How often do you have mood swings? 0 1 2 3 4

2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4

3. How often have you taken medication other than the way that it was prescribed?
   0 1 2 3 4

4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4

5. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

The Revised Oswestry Disability Index

SECTION 1-PAIN INTENSITY

0) The pain comes and goes and is very mild
1) The pain is mild and does not vary much
2) The pain comes and goes and is moderate
3) The pain is moderate and does not vary
4) The pain comes and goes and is very severe
5) The pain is severe and does not vary much

SECTION 2-PERSONAL CARE

0) I would not have to change my way of washing or dressing in order to avoid pain
1) I do not normally change my way of washing or dressing even though it causes some pain
2) Washing and dressing increases the pain, but I manage not to change my way of doing it
3) Washing and dressing increases the pain and I find it necessary to change my way of doing it
4) Because of the pain, I am unable to do some washing and dressing without help
5) Because of the pain, I am unable to do any washing and dressing without help

SECTION 3-LIFTING

0) I can lift heavy weights without extra pain
1) I can lift heavy weights, but it causes extra pain
2) Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g on a table)
3) Pain prevents me rom lifting heavy weights off the floor
4) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
5) I can only lift very light weights at the most

SECTION 4-WALKING

0) I have no pain while walking
1) I have some pain while walking, but it does not increase with distance
2) I cannot walk more than one mile without increasing pain
3) I cannot walk more than ½ mile without increasing pain
4) I cannot walk more than ¼ mile without increasing pain
5) I cannot walk at all without increasing pain

SECTION 5-SITTING

0) I can sit in any chair as long as I like
1) I can only sit in my favorite chair as long as I like
2) Pain prevents me from sitting more than one hour
3) Pain prevents me from sitting more than ½ hour
4) Pain prevents me from sitting more than 10 minutes
5) I avoid sitting because it increases pain right away

SECTION 6-STANDING

0) I can stand as long as I want without pain
1) I have some pain while standing , but it does not increase with time
2) I cannot stand for longer than one hour without increasing pain
3) I cannot stand for longer than ½ hour without increasing pain
4) I cannot stand for longer than 10 minutes without increasing pain
5) I avoid standing because it increases the pain right away

SECTION 7-SLEEPING

0) I get no pain in bed
1) I get pain in bed, but it does not prevent me from sleeping well
2) Because of pain, my normal night's sleep is reduced by less than ¼
3) Because of pain, my normal night's sleep is reduced by less than ½
4) Because of pain, my normal night's sleep is reduced by less than ¾
5) Pain prevents me from sleeping at all

SECTION 8-SOCIAL LIFE

0) My social life is normal and gives me no pain
1) My social life is normal, but increases the degree of pain
2) Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.)
3) Pain has restricted my social life and I do not go out very often
4) Pain has restricted my social life to my home
5) I have hardly any social life because of the pain

SECTION 9-TRAVELLING

0) I get no pain while traveling
1) I get some pain while traveling, but none of my usual forms of travel makes it any worse
2) I get extra pain while traveling, but it does not compel me to seek alternative forms of travel
3) I get extra pain while traveling, which compels me to seek alternative forms of travel
4) Pain restricts all forms of travel
5) Pain prevents all forms of travel except that done while lying down

SECTION 10-CHANGING DEGREE OF PAIN

0) My pain is rapidly getting better
1) My pain fluctuates, but is definitively getting better
2) My pain seems to be getting better, but improvement is slow at present
3) My pain is neither getting better nor worse
4) My pain is gradually worsening
5) My pain is rapidly worsening

Total: _____/ _____= _____%

Total score / (# of sections completed x 5)

US Pain & Spine Institute clinics are outpatient departments of the Houston Hospital for Specialized Surgery