University South
Charles H. Booras, MD, FAAFP
Richard Bowles, MD
Shelby Augustin, APRN

Pain Visit

Patient Information

Patient name _____ Date _____

Please describe the problem _____

_____

When did symptoms first start? _____

How often does it occur? (daily, weekly, etc.) _____

How long does it last? (minutes, hours, constant) _____

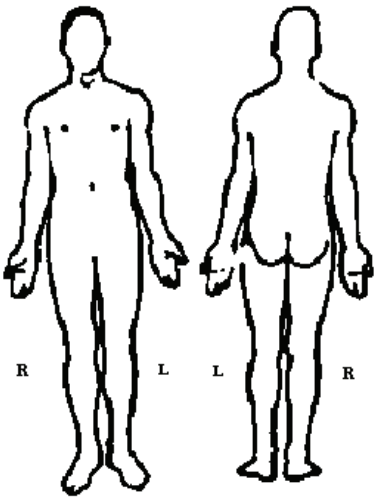
Quality of discomfort? (dull, achy, sharp, etc.) _____

Average pain level *Circle one:* 1-3 (Mild) 4-6 (Moderate)
7-8 (Severe) 9 (Crying) 10 (Extreme)

At its best, pain level is _____. At its worst, pain level is _____.

What worsens your pain? _____

_____



Please indicate the painful area

What helps your pain? _____

_____

Nicotine use: ❑ Yes ❑ No If yes, how much? _____

If you smoke, or use any form of tobacco, are you interested in quitting? ❑ Yes ❑ No

Alcohol use: ❑ None ❑ Less than 7 drinks a week ❑ 7-14 drinks a week ❑ More than 14 a week

Name of anyone in the exam room with you: _____

Review of Symptoms

*Please **check** all boxes for current symptoms and **circle** any new/worsening symptoms that you would like to have evaluated further (may require additional testing and appointment).*

❑ Fever (documented)	❑ Irregular heartbeats	❑ Abnormal bruising
❑ Excessive fatigue	❑ Chest pain/pressure	❑ Muscle or joint pain
❑ Abnormal weight change	❑ Swelling in feet	❑ Rash
❑ Headache	❑ Heartburn	❑ Breast mass or pain
❑ Eye issues	❑ Nausea or vomiting	❑ Numbness/tingling
❑ Nasal congestion	❑ Diarrhea	❑ Memory problems
❑ Sore throat	❑ Constipation	❑ Sad, hopeless
❑ Cough	❑ Black or bloody BM's	❑ Loss of interest
❑ Wheezing	❑ Urinary problems	❑ Excessive anxiety
❑ Shortness of breath	❑ Cold Intolerance	❑ Trouble sleeping
❑ Stop breathing at night	❑ Abnormally low sex drive	❑ Other (list below)

Other symptoms of concern? _____