

Michigan Pain Specialists

(734) 995-7246
3520 Green Court, Suite 100
Ann Arbor, MI 48105

Patient Name:
DOB:
Age:
Gender:

Office Visit Questionnaire

Date:
Please fill out all pages completely. This occurs at each visit. Thank you.

Patient Name: _____

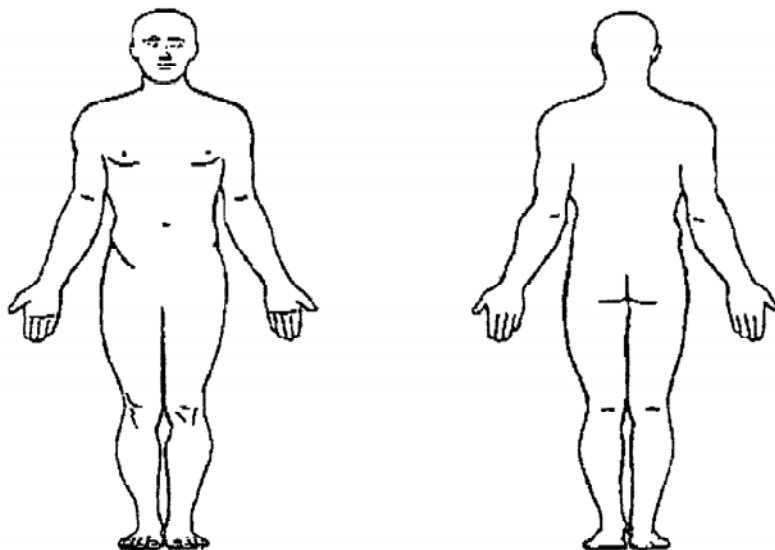
Referring Physician: _____

Primary Care Physician: _____

What is your current insurance? _____

Why have you come here today? _____

Please show the location of your pain by drawing on the figures below:



Has your pain improved since your last visit? **Yes / No** If yes, how long did your pain improve?

What was the maximum percent improvement? _____ %

What activities are you able to do as a result of your treatments?

Have you had any side effects from the treatment(s)? NO YES Explain:

Do you have any fever, chills, or active infections? NO YES Explain:

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Please mark where you are on the following scales (on average):

PAIN

BEST 1 2 3 4 5 6 7 8 9 WORST
0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

Have you had any of the following problems? Please circle Yes or No.

Yes / No Missing work because of pain	Yes / No Do you use cocaine	Yes / No Arrested for drug-related crimes
Yes / No Do you use alcohol with opioid medicines	Yes / No Do you use street drugs	Yes / No Selling your medications
Yes / No Involved in a lawsuit	Yes / No Do you smoke marijuana	

Do you take any of the following medications?

<input type="checkbox"/> Coumadin (warfarin)	<input type="checkbox"/> Lovenox (enoxaparin)	<input type="checkbox"/> Aggrenox
<input type="checkbox"/> Plavix (clopidogrel)	<input type="checkbox"/> Innohep (tinzaparin)	<input type="checkbox"/> NSAIDS
<input type="checkbox"/> Ticlid (ticlodipine)	<input type="checkbox"/> Fragmin (dalteparin)	<input type="checkbox"/> Aspirin
<input type="checkbox"/> Pletal (cilostazol)		<input type="checkbox"/> Trental (pentoxifylline)

List ALL drugs that have CHANGED since your last visit:

Drug	Dose	How often do you take it?	Physician Who Ordered

List all Allergies:

Have you had any tests done since your last visit (x-rays, MRI, blood tests)? **NO** **YES**

Please list:

Please circle all medical conditions that affect you:

Treating physician:

General Health	Fever, unintentional weight loss, HIV, Cancer Type _____
ENT	Cold symptoms, sinusitis, sore throat, hearing loss
Eyes	Glaucoma, cataracts, macular degeneration, blindness
Heart	Heart attack, heart failure, irregular rhythm, palpitations, chest pain, poor circulation, valve disease, high blood pressure
Lung	Cough, Asthma, COPD, Emphysema, Chronic Bronchitis, shortness of breath, Home oxygen use
Intestinal, stomach	Nausea/ vomiting, diarrhea, ulcers, constipation, reflux, liver cirrhosis, hepatitis, loss of bowel control
Renal	Renal failure, UTI, kidney stones, blood in urine, loss of bladder control, impotence
Hormonal	Diabetes, thyroid disease, calcium imbalance
Lymph node	Enlarged lymph nodes in neck, arm pits, or groin areas

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Muscle/bones	Arthritis, osteoporosis, lupus, rheumatoid arthritis, spinal stenosis, disc disease, neck pain, back pain, sciatica, radiculopathy
Skin	Rash, infection, blisters, psoriasis, dermatitis, eczema, Any skin infections or ulcers now or in the past
Brain/ Neurological	Stroke, seizures, paralysis, TIA, mini-strokes, facial drooping, slurred speech, neuropathy
Blood Disorders	Bleeding history, blood clots, Von Willebrand's Disease, Sickle Cell Anemia, Hemophilia, excessive bleeding when cut, easy bruising
Sleep/ Psychological	Insomnia, excessive tiredness, anxiety, depression

Are you, or could you, be pregnant? YES NO

Patient signature

Yes / No All other systems negative except those noted above.

Yes / No MRI **films** available and reviewed.

Yes / No MRI **report** available and reviewed.

Physician signature

I have personally reviewed this entire document.

_____ BP _____ SpO2 _____ Time

_____ HR _____ RR

_____ M.A.