Northeast Georgia PHYSICIANS GROUP
Interventional Pain Medicine

Follow-Up Visit Review of Systems

Name:_____ **Date:**_____ **DOB:**_____

REVIEW OF SYSTEMS (Circle any of the following symptoms you have experienced in the past 6 months):

Constitutional

Activity change

Appetite change

Fatigue

Fever

Unexpected weight change

HENT

Congestion

Ear pain

Hearing loss

Nosebleeds

Runny nose

Sinus pain

Sore throat

Ringing in the ears

Difficulty swallowing

Voice change

Eyes

Eye pain

Eye redness

Sensitivity to light

Visual disturbance

Respiratory

Chest tightness

Cough

Shortness of breath

Cardiovascular

Chest pain

Leg swelling

Palpitations

Gastrointestinal

Abdominal distention

Abdominal pain

Constipation

Diarrhea

Nausea

Vomiting

Endocrine

Cold intolerance

Heat Intolerance

Genitourinary

Painful urination

Urinary Frequency

Musculoskeletal

Joint pain

Back pain

Difficulty Walking

Joint swelling

Muscle pain

Neck pain

Skin

Color change

Rash

Allergies/Immune System

Food allergies

Immuno-compromised

Neurological

Dizziness

Headaches

Light-headedness

Numbness

Seizures

Speech difficulty

Syncope

Tremors

Weakness

Hematologic

Bruises/bleeds easily

Psychiatric

Agitation

Behavior problem

Confusion

Decreased concentration

Hallucinations

Nervous/anxious

Sleep disturbance

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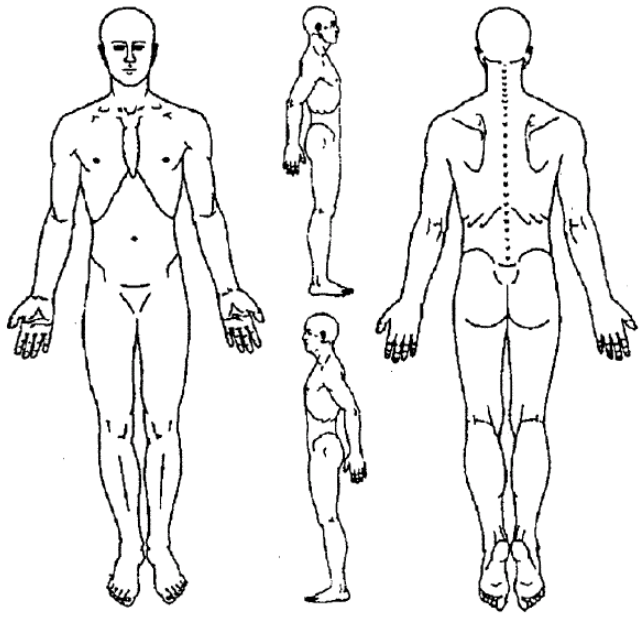
Pain Survey

Location: In what part of your body is your pain the worst?_____

Please mark the area(s) of injury or discomfort on the chart below:



Describe the quality and character of your pain. (Check all that apply)

Aching Burning Cold Electric Shock Dull Hot/Flushed Numb Tingling Stabbing
Sharp Pins & Needles Throbbing Other (describe):_____

Rate the severity of your pain *at its worst* on this scale (1 = mild, 10 = worst pain of your life):

1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Radiation/Referral Pattern: Does your pain travel to other locations? Yes No If yes, where?_____

Describe the frequency of your pain. Daily Weekly Monthly Constant Infrequent/episodic/irregular

Timing: At what time of day (or night) is the pain at its worst?_____

Aggravating Factors: What worsens the pain?_____

Alleviating Factors: What makes the pain better?_____

Activity: Are you exercising, walking, stretching, etc? _____

How Many Hours of Sleep do you average per night?_____ Would you consider this quality sleep? Yes No

How would you describe your mood? Irritable Sad Happy most of the time Other:_____

Are you currently working? (Circle one) Full-Time Part-Time Not Currently Working