

Dr. Daniel Heller Follow Up Packet (EVL3)

Patient Name: _____ Date of Appointment: ____/____/____

1. Where are you having the most severe pain?

 2. When did it start? _____

 3. Is your pain? constant Intermittent

 4. Is your injury/condition work/MVA related? Yes No Unsure
If yes; date of injury: ____ / ____ / ____

 5. Are you currently working? Yes No Retired? Disabled?

 6. Indicate what activity, if any, seemed to CAUSE your current pain condition:

 7. What makes your pain better? (Name 3 things if you can, i.e. standing, sitting, and changing position, certain medications, rest...)

 8. What makes your pain worse? (Name 3 things if you can, i.e. standing, sitting, walking, lying down...)

 9. Are you currently taking any prescribed pain medications? If so what medications and doses?

 10. If you are taking pain medications are they helping?

 11. Please name 3 things you are able to do that you would not be able to do without the help of the medications? (ie. sleep or rest, work, stand longer, sit longer, do heavy chores...)
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11. Previous Treatment

Please indicate if you have received any of the following treatments for your Pain condition, when the treatment occurred, and whether the outcome was positive (+) or negative (-)

Treatment	Approximate Month & Year	Results (+ or -)
Surgery		
Physical Therapy		
Chiropractic treatment		
Injections guided by x-ray		
<input type="checkbox"/> Epidural Steroid		
<input type="checkbox"/> Facet Injection		
<input type="checkbox"/> Sacroiliac Joint		
<input type="checkbox"/> Hip Joint		
<input type="checkbox"/> Other		

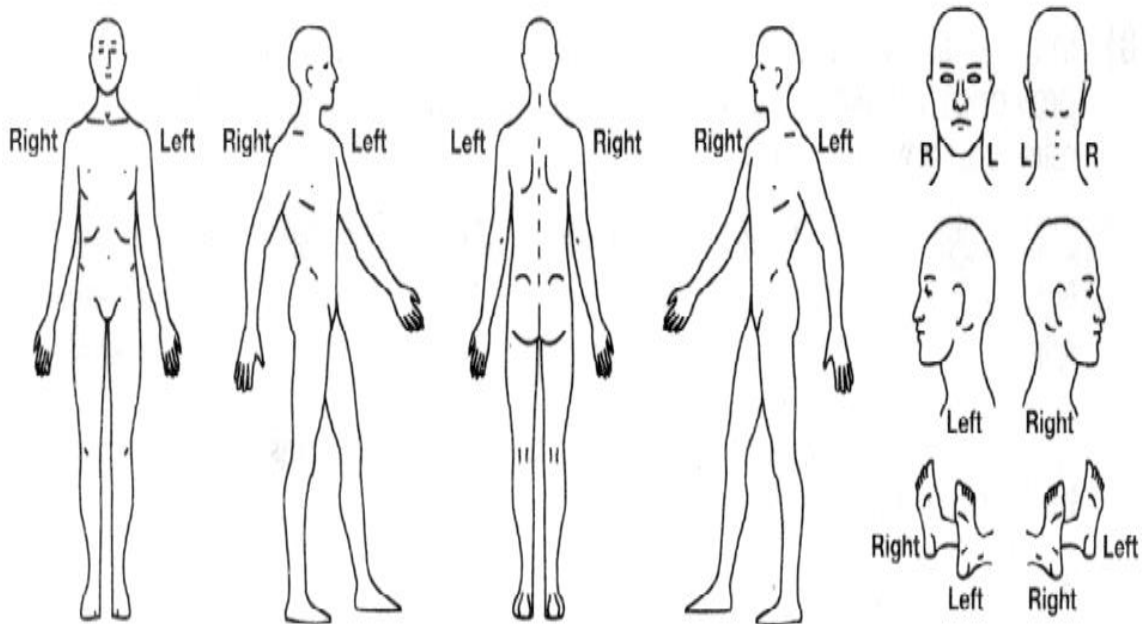
PAIN LINE: Draw a perpendicular line or arrow to indicate your usual level of pain

No PAIN
0

Worst possible PAIN
10

|_____|

PAIN DIAGRAM: Please outline the area where you have pain



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Date of Appointment: ____/____/____

Account #: _____

Review of Systems: Please check [] any of the following symptoms you are having:

<p style="text-align: center;">Constitutional</p> <input type="checkbox"/> unexplained weight loss/gain <input type="checkbox"/> new weakness <input type="checkbox"/> fevers/chills/night sweats <input type="checkbox"/> NONE	<p style="text-align: center;">Cardiovascular</p> <input type="checkbox"/> new chest pain/pressure/tightness <input type="checkbox"/> irregular heart rate/beat <input type="checkbox"/> trouble breathing while lying <input type="checkbox"/> high blood pressure <input type="checkbox"/> NONE	<p style="text-align: center;">Gastrointestinal</p> <input type="checkbox"/> acid reflux <input type="checkbox"/> history of stomach ulcer <input type="checkbox"/> bloody or dark stools <input type="checkbox"/> constipation <input type="checkbox"/> nausea/vomiting <input type="checkbox"/> hepatitis A/B/C <input type="checkbox"/> NONE
<p style="text-align: center;">Integumentary</p> <input type="checkbox"/> new rash <input type="checkbox"/> frequent bruising <input type="checkbox"/> itching <input type="checkbox"/> bleeding <input type="checkbox"/> nail or hair changes <input type="checkbox"/> hives <input type="checkbox"/> sores that don't heal <input type="checkbox"/> NONE	<p style="text-align: center;">Ear/Nose/Throat</p> <input type="checkbox"/> vertigo/dizziness <input type="checkbox"/> loss of hearing <input type="checkbox"/> ringing in the ear <input type="checkbox"/> nose bleed <input type="checkbox"/> trouble swallowing <input type="checkbox"/> NONE	<p style="text-align: center;">Musculoskeletal</p> <input type="checkbox"/> joint pain / stiffness <input type="checkbox"/> joint redness and swelling <input type="checkbox"/> muscle cramps <input type="checkbox"/> new weakness <input type="checkbox"/> NONE
<p style="text-align: center;">Neurological</p> <input type="checkbox"/> new headache <input type="checkbox"/> blackouts or fainting <input type="checkbox"/> tingling / numbness <input type="checkbox"/> paralysis <input type="checkbox"/> seizures <input type="checkbox"/> memory loss <input type="checkbox"/> NONE	<p style="text-align: center;">Respiratory</p> <input type="checkbox"/> shortness of breath <input type="checkbox"/> sleep apnea <input type="checkbox"/> cough - new or chronic? <input type="checkbox"/> tuberculosis <input type="checkbox"/> NONE	<p style="text-align: center;">Genitourinary</p> <input type="checkbox"/> blood in the urine <input type="checkbox"/> urgency to urinate <input type="checkbox"/> loss of bladder control <input type="checkbox"/> frequent urination <input type="checkbox"/> new difficulty urinating <input type="checkbox"/> NONE
<p style="text-align: center;">Eyes</p> <input type="checkbox"/> blurry vision <input type="checkbox"/> double vision <input type="checkbox"/> cataracts <input type="checkbox"/> glaucoma <input type="checkbox"/> eye pain <input type="checkbox"/> NONE	<p style="text-align: center;">Psychological</p> <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> thoughts of suicide, hurting yourself or anyone else <input type="checkbox"/> trouble falling asleep <input type="checkbox"/> NONE	<p style="text-align: center;">For Clinical Use only</p> <p>Ht. _____ Wt. _____</p> <p>B/P _____ P _____</p>

Do you want me to arrange special treatment or counseling, for depression, anxiety, or if you are having any thoughts of hurting yourself or anyone else? Yes No NA

Have you ever had any problems with drug (including prescription) or alcohol abuse or misuse (including DUI or any drug or alcohol related charges or convictions)?

Findings were reviewed and confirmed with the patient

Daniel S. Heller, MD