NYC PAIN SPECIALISTS

a Trusted Pain Physician Company

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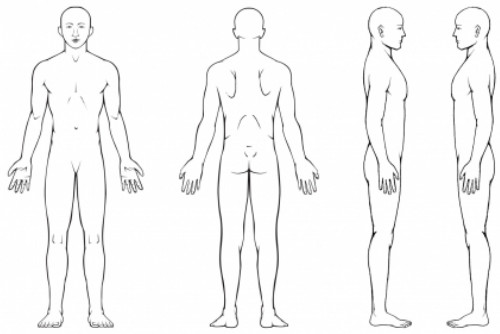
41 East 11th Street (at Broadway)
New York, New York, 10003

FOLLOW-UP PATIENT HISTORY FORM

PATIENT NAME:_____ **DOB:**_____**DATE:**_____

Has your medical coverage changed from your last visit? _____ Has your address changed from your last visit? _____
Please Indicate the Location of Your Pain
Chief Complaint (Reason for Visit):_____

Pain Level:(Mild) 0 1 2 3 4 5 6 7 8 9 10 (Severe) Occasional / Frequent / Constant



Is pain aggravated by? Sitting Standing Walking Bending forward / backward
Is pain alleviated by? Sitting Standing Walking Bending forward / backward
Pain Description: Dull/Aching Burning Sharp Shooting Throbbing
Electrical Cramping Tightness Spasm

Changes to your PAIN Since Your Last Visit:
Have you developed new pain that you would like to discuss today?
_____
If so, is the new pain due to a motor vehicle accident or personal injury?
_____
Since your last appointment, how has your pain changed? _____ Decreased _____
Increased _____ Same
If you had a procedure, how much pain relief did you get? ___ None ___ 10% ___ 25% ___ 50% ___ 75% __ 100%
Were there any problems? ____Yes ____ No If yes, explain: _____

Changes to your Medical History Since Your Last Visit:
Please list any Hospitalizations, Surgeries, Procedures, Dental or PCP Visits: _____

Since your last visit, have your developed any new:	**Review of Systems:** Circle all that apply:
Numbness / Tingling, Weakness, Bladder/Bowel Incontinence, Balance Problems, Fever / Chills, Joint Stiffness, Weight Loss	Trouble sleeping, Lungs/Breathing, Neurological, Chest Pain, Headaches,Thyroid, Fatigue, Nausea, Vomiting, Bleeding, Vision, Memory, Dizziness, Psychiatric, Skin, Ringing in Ears, Joints/Bones, Muscles, Reproductive, Urinary

I have not developed problems with any of the above conditions since my last visit_____

Any CHANGES to your Medications/Dose/Frequency
1._____ 2._____
3._____ 4._____
Are you taking any anticoagulants? ___Yes ____No Any side-effects from the medication regimen? _____
Allergies:_____ Latex: Yes No **Contrast Dye:** Yes No

_____ _____ _____ _____
Patient Signature **Date** **Physician Signature** **Date**

Please call our office with any questions or concerns:
212.371.8460