Northwest Pain Care, Inc.

421 West Riverside Avenue, Spokane, Washington 99201 Phone: 509.863.9789 Fax: 855.630.0757 Web: WWW.Northwestpaincare.com

Intrathecal Pump Follow-up Visit Form

Please complete this form for the pain location that we have been treating.

We will be unable to see you unless this form is completely filled out. We appreciate your thoroughness.

Name _____ Age _____ Today's Date _____

Referring doctor: _____ Primary doctor: _____

Where (what location) is your pain? _____

What does it feel like? Please check all that apply.

☐ **Aching**: ☐ Continuous ☐Intermittent ☐ **Dull**: ☐ Continuous ☐Intermittent

☐ **Sharp**: ☐ Continuous ☐Intermittent ☐ **Shooting**: ☐ Continuous ☐Intermittent

☐ **Burning**: ☐ Continuous ☐Intermittent

Does the pain radiate? ☐ Yes ☐ No

If yes, to where? ☐ Left ☐Right

Please describe:

Rate your pain on a scale of 0 to 10. 0 is no pain and 10 is the worst pain imaginable.

Current pain: ___/10 **Average pain**: ___/10 **Least pain**: ___/10 **Worst pain**: ___/10

Rate your activity level on a scale of 0 to 10. 0 is no activity and 10 is full activity.

Current Activity_____ **Average Activity**_____ **Least Activity**_____ **Most Activity**_____

Do you use your PTM(bolus) device for breakthrough pain? ☐ Yes ☐ No

If the boluses help, how much? ☐ a little ☐ some ☐ a great deal

What percentage of relief have you had since your pump was implanted? _____% Relief

Have you had any side effects? ☐ Yes ☐ No

If yes, please select: ☐ constipation ☐ itching ☐ drowsiness ☐ dizziness ☐ nausea

☐vomiting ☐ imbalance ☐ hallucinations ☐ difficulty breathing ☐ confusion ☐ memory loss

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Have you had any NEW loss of control of bowel function? □ Yes □ No

If yes, explain?

Have you had any NEW loss of control of bladder function? □ Yes □ No

If yes, explain?

Have you had any RECENT (within 3 months) non-purposeful weight loss? □ Yes □ No

If yes, explain?

Have you had any RECENT numbness (inability to feel) in your arms/legs? □ Yes □ No

If yes, where? {Arm(s) or leg(s)}

Have you had any tingling (sensation that your arms/legs are falling asleep)? □ Yes □ No

If yes, explain? {Arm(s) or leg(s)}

Have you had any RECENT weakness? □ Yes □ No

If yes, where? {Arm(s) or leg(s)}

How far can you walk without stopping due to pain?

_____ □ Miles □ Blocks

How long can you stand up straight without moving at all?

Less than _____ minutes

Do you bend over and hold on to a cart while shopping?

□ Yes □ No

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Imaging:

Have you had any new imaging since we last saw you**?** □ Yes □ No

Please List:

_____

_____

Do you have any NEW MEDICAL PROBLEMS? □ Yes □ No

Please list any new medical problems

Have you had any SURGERIES since your last visit? □ Yes □ No

Please list any new surgeries.

Do you have any NEW ALLERGIES? □ Yes □ No

Please list any new allergies.

Medications: Please list all medications. **Make sure to list all blood thinners**.

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Review of Systems: Please check ALL that currently apply to you.

Constitutional:

☐ Chills ☐ Fatigue ☐ Recent Fever ☐ Generalized Weakness
☐ Recent Weight Gain ☐ Recent Weight Loss

Eyes:

☐ Blurry vision ☐ Cataracts ☐ Eye discharge ☐ Double vision ☐ Excessive tearing
☐ Eye pain ☐ Eyeglass use ☐ Glaucoma ☐ Eye infections ☐ Pain w/ light
☐ Recent eye injury ☐ Eye redness ☐ Vision loss

ENT:

☐ Nasal discharge ☐ Frequent colds ☐ Hay fever ☐ Nasal obstruction ☐ Recent nose bleeds
☐ Chronic sinusitis ☐Recent gum bleeding ☐ Change in dentition ☐ Recent hoarseness ☐ Dentures
☐ Ear discharge ☐ Dizziness ☐ Hearing aid use ☐Ear infections ☐ Ear pain
☐ Ringing in the ears ☐ Hearing loss ☐ Frequent sore throats ☐ Neck tenderness ☐ Enlarged tonsils
☐ Neck mass

Respiratory:

☐ Asthma ☐ Recent cough ☐ Recent wheezing ☐Bronchitis ☐ Coughing up blood
☐ Pleurisy (Pain with Breathing) ☐ Shortness of Breath ☐ Sputum production ☐ History of TB
☐ Recent pneumonia ☐ Recent night sweats ☐ Recent chest wall pain

Cardiovascular:

☐ Recent chest pain ☐ Congestive heart failure ☐ Palpitations ☐ Varicose veins
☐ Cool extremities ☐ Discolored extremities ☐ Heart murmur ☐ High blood pressure
☐ History of heart attack ☐ Leg pain while walking ☐ History of rheumatic fever
☐ Shortness of breath with exertion ☐ Leg swelling ☐ Leg ulcers ☐ Mitral valve prolapse
☐ Unable to breathe while flat ☐Difficulty breathing

Gastrointestinal:

☐ Recent abdominal pain ☐ Recent constipation ☐ Recent Diarrhea ☐ Recent heartburn
☐ Jaundice ☐ Liver disease ☐ Rectal bleeding ☐ Black, tarry stools
☐ Recent change in stool color ☐ Decreased appetite ☐ Excessive Thirst ☐ Gallbladder disease
☐ Hemorrhoids ☐ Recent nausea ☐ Recent vomiting ☐ Difficulty swallowing
☐ Bloody stools ☐ Hepatitis C ☐ Hepatitis B ☐ Hepatitis A
☐Vomiting up blood ☐ Increased appetite

Musculoskeletal:

☐ Arthritis ☐ Joint pain ☐ Gout ☐ Back problems ☐ Joint stiffness
☐ Muscle cramps ☐ Muscle stiffness ☐ Muscle weakness ☐ Neck problems ☐ Mid-back problems

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Psychiatric:

☐ Recent anxiety ☐ Recent depression ☐ Recent behavioral change ☐ Recent disorientation
☐ Disturbing thoughts ☐ Excessive stress ☐ Hallucinations ☐ Memory loss
☐ Mood changes ☐Suicidal thoughts ☐ Panic attacks ☐ Bipolar disease
☐ Paranoia ☐ Schizophrenia ☐ Personality disorder ☐Previous psychiatric care
☐ Suicide attempts ☐ Inability to sleep ☐ Obsessive/Compulsive ☐ Nervousness

Skin:

☐ Eczema ☐ Itching ☐ Dryness ☐ Easy Bruisability ☐ Hair texture change
☐ Hives ☐ Lumps ☐ Increased mole size ☐ Nail changes ☐ Recent rashes
☐ Skin color change ☐ New skin moles

Neurological:

☐ Burning sensation ☐ Dizziness ☐ History of head injury ☐ Recent headaches
☐ Recent memory loss ☐ Recent numbness ☐ History of paralysis ☐ Strokes
☐ Recent tingling ☐ Recent tremors ☐ Unsteady gait ☐ Seizures
☐ Discoordination ☐ Recent passing out ☐Speech difficulty

Endocrine:

☐ Recent weight gain ☐ Recent weight loss ☐ Intolerance to cold ☐ Fatigue ☐ Goiter
☐ Intolerance to heat ☐ Increased thirst ☐ Recent sweats ☐ Thyroid trouble ☐ Excessive urination

Hematological/Lymph:

☐ Bleeding tendency ☐ Anemia ☐ Blood clots ☐ Radiation exposure
☐ Transfusion reaction ☐ Tender lymph nodes ☐ Swollen lymph nodes
☐ Current Blood thinner use ☐ History of blood transfusions ☐ Easy bruising

Allergy/Immunologic:

☐ Hives ☐ Itchy eyes ☐ Itchy nose ☐ Recurrent infections
☐ Runny nose ☐ Sneezing ☐ Watery eyes ☐ Wheezing ☐ Food allergies
☐ Insect allergies ☐ Dye allergy ☐ Pollen/Seasonal allergy ☐ Environmental allergy

Urinary:

☐ Blood in urine ☐ Difficulty starting stream ☐ Recent flank pain ☐ Incontinence
☐ Urine odor ☐ Difficulty urinating ☐ Kidney failure ☐ Dialysis
☐ Sexual difficulty ☐ Frequent UTI's ☐ Urinary burning ☐ Unusual urine color
☐ Elevated creatinine ☐ Endometriosis ☐ Painful menstrual cycle ☐ Prostate problems
☐ Frequent urination ☐ Kidney stones ☐ Painful urination ☐ Urinary retention
☐ Kidney transplant ☐ Awakening to urinate ☐ Nighttime Urination ☐ Urgent Urination

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Smoking:

Have you stopped smoking since the last visit? □ Yes □ No

When did you quit smoking? Month _____ Day _____ Year _____

Have you started smoking since the last visit? □ Yes □ No

When did you start smoking? Month _____ Day _____ Year _____

Do you smoke every day? □ Yes □ No

Do you smoke some days? □ Yes □ No

How much do you smoke? Packs _____ per day.

Please draw on the diagram where your pain is:

Right **Front** Left Left **Back** Right