FOLLOW UP PAIN MANAGEMENT QUESTIONNAIRE

Patient Full Name: ____Date of Birth: ______________

Where is your pain located:____

When does your pain mostly occur? *(Example: sitting, standing, etc.)* ______________________________

What makes your pain worse? ____

What makes your pain better? ____

Does your pain impact your sleep? (Circle One): Yes No

Date of last urine drug screen (if known): ____

What is your pain level today on a scale of 1-10: ________ with meds_______ without meds _______

What is your activity level impairment (1-10): without med ____________ with med: ________________

Do you have any adverse effects from the opioid medication (check all that apply):

☐Nausea/vomiting ☐Confusion

☐Constipation ☐Falls

☐Dry Mouth ☐Increased sensitivity to pain

☐Itching ☐Depression

☐Sweating ☐Physical Dependence

☐Sleepiness/dizziness ☐Low Testosterone/libido/energy