The Spine and Orthopedic Center

RETURN VISIT PATIENT HISTORY

Parish Vaidya, MD

PATIENT_________________________________ DOB _______________ Today's Date_______________

Reason for follow-up visit: (Circle all that apply.)
Pharmacologic pain management Due to recurring symptoms For a new problem After an injection
After diagnostic testing After starting physical therapy To discuss treatment options

Generally speaking, how are your symptoms? (Circle one) Better Worse Same

Describe any symptom changes since your last visit:____

____

____

Have any medications changed since your last visit? (Circle one): Yes No
If yes, please describe changes: ____

____

Describe the effect of your current pain medications: (Check all that apply)
○ Increase my activity ○ Cause me to be too sleepy ○ Make it difficult to function
○ Improve my sleep ○ Have no benefit ○ Decrease my pain level
○ Causes side effects ○ Other:___________________________
Explain: ___________

Did you have an injection or surgery since your last visit? (Circle one) Yes No
What percentage of relief did you have from the procedure?_______%

Are you receiving physical therapy or chiropractic treatment? Yes No (circle)

If so where:_________________________________How many days per week:____________________________

What physical therapy or chiropractic treatments are you receiving?____

Have you had any acupuncture since your last visit? Yes No (circle)

Have you had any medical tests since your last visit such as x-rays, MRI, blood tests, etc? Yes No (circle)
What and Where?____

Have you seen any other doctors since your last visit? Yes No (circle)
What has been changed or treated? ____

Have you been treated at a hospital since your last visit? Yes No (circle)
Please explain:____

____

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Check all that apply since your last visit: ☐ None apply:

- ☐ Stomach pain
- ☐ Urinary incontinence
- ☐ Bowel incontinence
- ☐ Fever or chills
- ☐ Thoughts of hurting myself or others
- ☐ Nausea or vomiting
- ☐ Frequent diarrhea
- ☐ Seizures
- ☐ Swollen ankles or legs
- ☐ Frequent Constipation
- ☐ Frequent headaches
- ☐ Bleeding w/bowel movements
- ☐ Unintentional weight loss
- ☐ Other: ________________

Circle the number that best describes your CURRENT PAIN with "10" being the most severe.

Back/Leg 0 1 2 3 4 5 6 7 9 10 Neck/Arm 0 1 2 3 4 5 6 7 9 10

Circle the number that best describes your AVERAGE DAILY PAIN with "10" being the most severe.

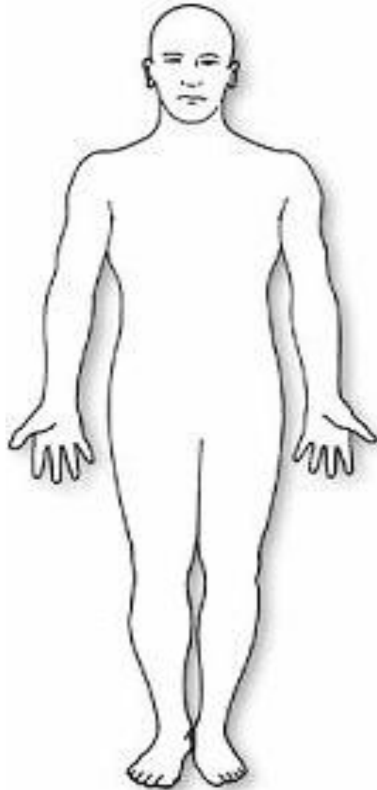
Back/Leg 0 1 2 3 4 5 6 7 9 10 Neck/Arm 0 1 2 3 4 5 6 7 9 10

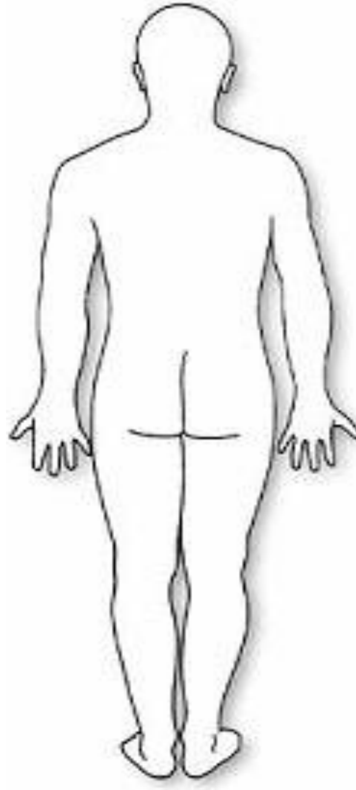
Mark these drawings using the symbols that best describe your pain:

Numbness = = = = = = = Aching ^ ^ ^ ^ ^ ^ Pins and needles o o o o o o o

Stabbing / / / / / / / / / / / / Burning x x x x x x Cramping ●●●●●●●●

FRONT **BACK**





Any additional comments:____

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