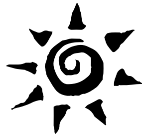
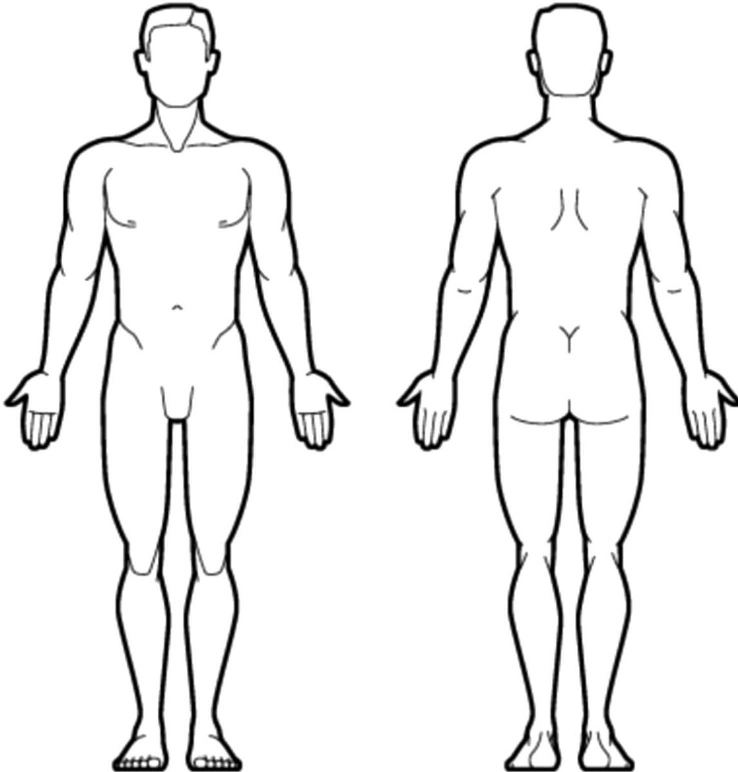


SUNCOAST PAIN MANAGEMENT

SunCoast Pain Management, P.A.
Office Visit Questionnaire

Patient Name: ___________________________________
Date:_________________________

Where is the pain located?



Analgesia
PEG SCORE: ______

1. **What number from 0 – 10 best describes your pain in the past week?**

   0 1 2 3 4 5 6 7 8 9 10

2. **What number from 0 – 10 describes how, during the past week, pain has interfered with your enjoyment of life?**

   0 1 2 3 4 5 6 7 8 9 10

3. **What number from 0 – 10 describes how, during the past week, pain has interfered with your general activity?**

   0 1 2 3 4 5 6 7 8 9 10

What is the lowest your pain level has been in the last week?

0 1 2 3 4 5 6 7 8 9 10

What is the most your pain level has been in the last week?

0 1 2 3 4 5 6 7 8 9 10

Activities

How much total time do you walk the whole day? (8 min per hour is about 2 hrs total per day)

30 min 60 min (2,000 steps) 90 min 2hrs (4,000 steps) 2.5 hrs

3 hrs (6,000 steps) 3.5 hrs 4 hrs (8,000 steps) 4.5 hrs >5hrs (>10,000 steps)

What other exercises do you do besides walking?

Running Bicycling Weight Training Swimming Other_______ NONE

Affect: Mood with Pain Management Treatment:

Family Relationships	Better	Same	Worse
Social Relationships	Better	Same	Worse

How many hours sleep per night? 2 4 6 8 10 >10

Adverse Effects if being prescribed Pain Medications

Constipation	Yes	No
Drowsiness	Yes	No
Fatigue	Yes	No
Itching	Yes	No
Mental Cloudiness	Yes	No
Nausea	Yes	No

Aberrant Behavior

Pain Medications from other Providers since last visit? Yes No

Taken any illegal drugs since last visit? Yes No

Consume Alcohol since last visit? Yes No

Last time took any pain medications? (hrs) <2 2-4 4-6 6-8 8-10 10-12 >12

Current Address:

____

____

Current Insurance:

____

Current Medications:

Who is your Primary Care Provider: ____________________________________

May we send them the visit note from today? YES or NO