Melbourne Spine
Comprehensive Pain Management Specialists

1571 Aurora Rd. | Melbourne, FL | 32935
Tel: 321-254-9060 | Fax: 321-259-6456
pain@melbournespine.com | melbournespine.com

Name:

DOB:

Today's Date:

_____ / _____ / _____

PAIN HISTORY FOLLOW-UP

Are you having any new pain since your last visit? If yes, please describe below:

_____

_____

MEDICATION FOLLOW-UP (SKIP IF NOT ON PAIN MEDS)

To what extent are the medications improving your quality of life or ability to get through the day?

❑None ❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

Mark the following medication side-effects you are experiencing, if any:

❑Confusion ❑Constipation ❑Dizziness ❑Drowsiness ❑Dry Mouth ❑Nausea ❑Vomiting

❑Weight Gain ❑Sexual (describe): _____ ❑NONE

Are you currently taking any blood-thinners or anticoagulants?

❑YES ❑NO [**If YES**, please list these meds: _____]

Are you currently taking any antibiotics?

❑YES ❑NO

If YES, please list these medications: _____

If YES, what condition(s) are you treating? _____

PROCEDURE FOLLOW-UP (SKIP IF NO PROCEDURE)

1. **What procedure are you here to follow up for?**

❑Epidural Steroid Injection ❑Facet Injection ❑Joint Injection ❑Nerve Block ❑Sacroiliac Joint injection
❑Radio Frequency Ablation ❑Spinal Cord Stimulator ❑Other (please describe): _____ ❑Unknown

2. **How much pain relief did you obtain from that procedure?**

❑None ❑10% ❑20% ❑30% ❑40% ❑50% ❑60% ❑70% ❑80% ❑90% ❑100%

3. **How long did that relief last?** _____

4. **Did you tolerate that procedure well?**

❑Yes ❑No: Please explain (for example: side effects, adverse reactions, etc.): _____

PLAN (*office use only*):