North American Partners in Pain Management, LLP

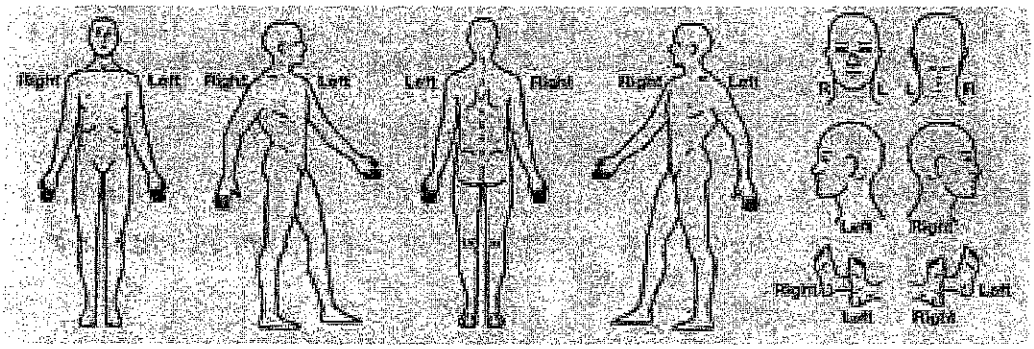
Follow-up Visit Questionnaire

Name: _____ Email: _____Today's Date: ___/___/___

Rate your average pain using this pain scale 0 to 10:

0	1	2	3	4	5	6	7	8	9	10
No pain		mild		discomfort		distressing		horrible		excruciating

Mark where your pain is located:



How has your pain changed since your last visit?

What is your current Height? _____ Weight? _____ Latest blood pressure? _____/_____

Do you ever smoke? Never Quit Yes → Packs per day: _____

What is your pharmacy name and address? _____

List your medication names & doses:	List all major medical problems:	List all allergies/reactions:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.
8.	8.	8.
9.	9.	9.