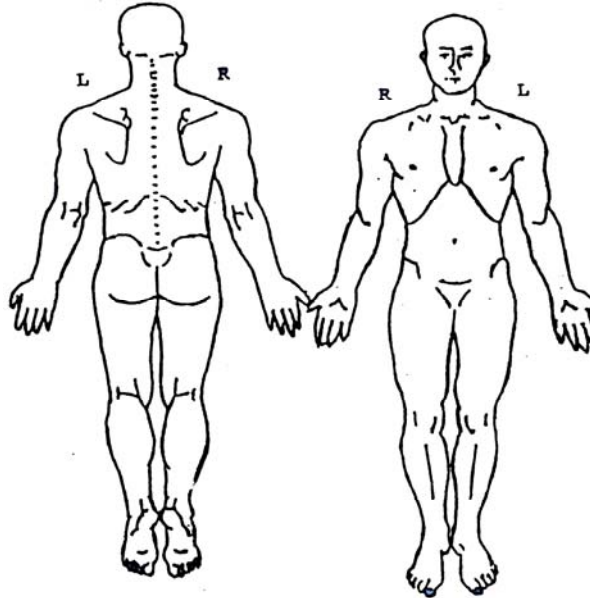


Consultants In Pain Medicine, P.A.

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Pink = Pain

Blue = Numbness



Date: _____

Name: _____

D.O.B.: _____

Primary Care Physician: _____

Medication Allergies: _____

BP: _____ P: _____ R: _____

All Current Medications: _____

PLEASE ANSWER ALL QUESTIONS BELOW DOI: _____

CIRCLE BEST DESCRIPTION

Pain Levels: Today (Circle One)

Past Week (Circle One)

Low 1 2 3 4 5 6 7 8 9 10 High

Low 1 2 3 4 5 6 7 8 9 10 High

Type of visit: New Patient Established Patient Procedure Consult Re-evaluation

Circle ALL of the following that apply:

1. Chills, fever, fatigue, weight gain _____ lbs, weight loss _____ lbs.
2. Blurred vision, eye pain, sensitivity to light, glasses, contacts
3. Hearing problems, ear pain, congestion, runny nose, nose bleeds
4. Chest pain, rapid heart beat, heart flutter, ankle swelling, shortness of breath.
5. Cough, difficulty breathing, bloody sputum
6. Abdominal pain, heartburn, constipation, diarrhea, stool changes.
7. Genital lesions, genital discharge, bloody urine, difficult urination, frequent urination, menstrual problems
8. Back pain, muscle spasms, joint pain
9. Dry skin, skin rashes, atypical moles, masses
10. Dizziness, headaches, numbness, weakness, seizures
11. Easy bruising, bleeding, enlarged lymph nodes, HIV /AIDS
12. Anxiety, depression, feelings of stress, problems with sleep, suicidal thoughts

DOCTOR USE ONLY

Location of Pain? _____

Is your pain? Mild Moderate Severe Constant Intermittent Better Worse Unchanged

Percentage of Change? Better _____ Worse: _____

Pain Quality: Sharp - Shooting - Dull - Aching - Stabbing - Tingling - Shooting - Other: _____

What makes the pain better? Rest - Lying Down - Walking - Medications - Massage - Chiropractic - Nothing
Other: _____

What makes the pain worse? Activity - Driving - Standing - Walking - Lying down - Other: _____

Sleep quality: Good - Fair - Poor **Pain is worse:** Morning - Afternoon/Evening - Night - Other: _____

New Diagnosis, Treatments or Medications since last visit: _____

NOTES:
