

PAIN DOC PAIN MANAGEMENT

Patient Name: _____

Date of Birth: _____

Date of Service: _____

Chief Complaint: Follow Up, _____

HPI: Onset/Duration: _____

Location: _____

Modifying Factors: _____

Intensity: /10

PFSH: Reviewed Modified to include _____

Allergies: Reviewed Modified to include _____

Medications: Reviewed Modified to include _____

Review of Systems: Reviewed Modified to include _____

General: Vital Signs-- Blood Pressure - _____ Pulse - _____ Respirations - _____

PHYSICAL EXAM

Normal

Abnormal

EYES: <input type="checkbox"/> Conjunctivae non-inflamed <input type="checkbox"/> Extraocular movements intact <input type="checkbox"/> No lid-lag <input type="checkbox"/> Pupils symmetric, reactive to light	
HENT: <input type="checkbox"/> Normocephalic/Atraumatic <input type="checkbox"/> Pinnae without scars, lesions or masses <input type="checkbox"/> Septum midline <input type="checkbox"/> Oral mucosa pink & moist	
NECK: <input type="checkbox"/> ROM within functional limits <input type="checkbox"/> Trachea midline <input type="checkbox"/> No thyromegaly <input type="checkbox"/> No lymphadenopathy	
CARDIOVASCULAR: <input type="checkbox"/> RRR <input type="checkbox"/> No murmurs, gallops, or rubs <input type="checkbox"/> No edema in extremities <input type="checkbox"/> Peripheral pulses palpable	
PULMONARY: <input type="checkbox"/> Respirations non-labored <input type="checkbox"/> Lung fields clear to auscultation and percussion bilaterally	
GI: <input type="checkbox"/> Normoactive bowel sounds <input type="checkbox"/> No tenderness to palpation <input type="checkbox"/> Liver and spleen nontender with no enlargement <input type="checkbox"/> No hernias	
MUSCULOSKELETAL: <input type="checkbox"/> Gait coordinated & smooth <input type="checkbox"/> Full ROM in joints <input type="checkbox"/> No muscular atrophy or weakness <input type="checkbox"/> Good strength in extremities bilaterally	
SKIN: <input type="checkbox"/> No rashes, lesions, ulcers <input type="checkbox"/> Resilient, warm & dry <input type="checkbox"/> No discoloration	
NEUROLOGIC: <input type="checkbox"/> Cranial nerves II-XII intact <input type="checkbox"/> DTR's present and symmetric bilaterally <input type="checkbox"/> Sensation intact to touch and pressure.	

ASSESSMENT

1] _____

2] _____

3] _____

4] _____

PLAN

Continue present management

Schedule _____

Order _____

Rx: _____

Refer to _____

Return to care of referring physician

Discharge, follow up prn

Follow up _____ day(s) _____ weeks _____ months

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