Follow-up Visit Questionnaire

Name: __________________________  Email: __________________________  Today’s Date: ___/___/___

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

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td>mild</td>
<td>discomfort</td>
<td>distressing</td>
<td>horrible</td>
<td>excruciating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mark where your pain is located:

![Body diagram indicating pain locations](image)

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.