Baylor College of Medicine

RETURN VISIST PATIENT QUESTIONNAIRE-
For Dr Benoy Benny

Dear Patient:

Please complete this questionnaire before you come for your appointment. Be sure to call us as soon as possible if you cannot make your appointment. Thank you.

Section 1: Questions About Your Current Problem

1. When were you last seen?_____
2. What are you being seen for?

_____

_____

3. Describe your current Pain? _____

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2. Generally speaking, are your symptoms getting better, worse or the same**?** _____

3. Circle the number between 0 and 10 to indicate your level of pain in this last week:

Worst this week (no pain)	0	1	2	3	4	5	6	7	8	9	10 (worst possible pain)
Best this week (no pain)	0	1	2	3	4	5	6	7	8	9	10 (worst possible pain)
Average this week (no pain)	0	1	2	3	4	5	6	7	8	9	10 (worst possible pain)

Section 4:Treatment History

10. Please write all treatments you have received for this problem since the last visit:

□ Medication changes

_____

_____

□ Physical Therapy and/or Occupational Therapy. Where and Dates_____
What did they teach you to do?

_____

_____

_____

□ Injections or Nerve Blocks. Where and Dates _____
Do you know what injections were done?

_____

_____

Surgery? If yes, what?

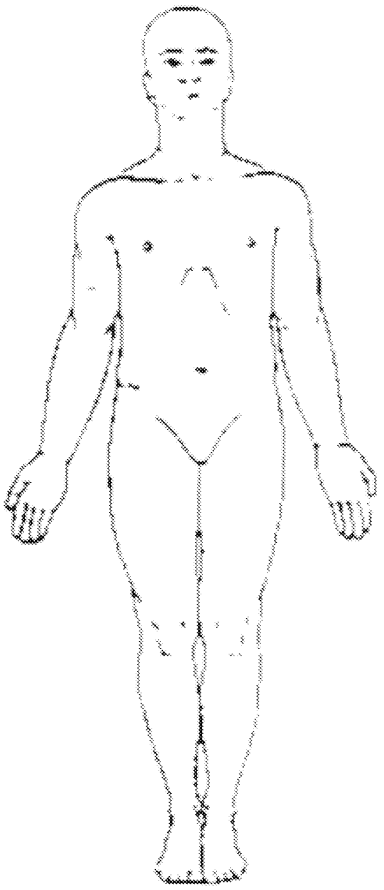
_____

□ Manipulation or other chiropractic treatment
□ TENS
□ Psychological/Psychiatric Counseling
□ Acupuncture
□ Pain Program . Dates:_____
What did they do? _____
□ Massage
□ Homeopathic or other alternative medicine (please list): _____

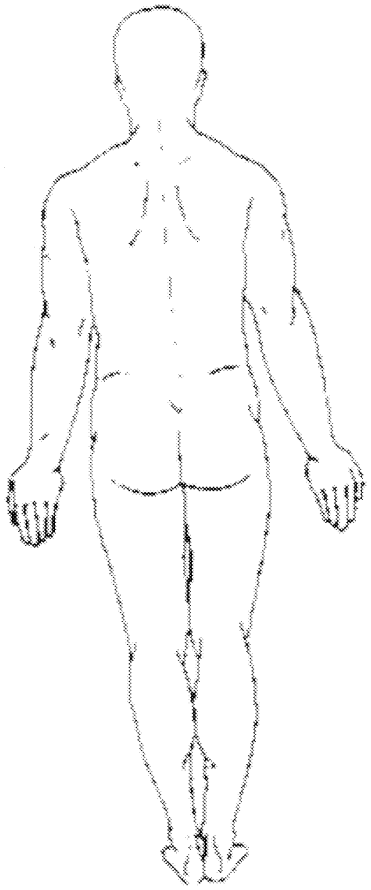
Section 3. Where is your pain located?

Mark the areas on the body where you feel the described sensations using the following markings:

Burning		Achiness	1 1 1 1
Numbness	- - - - - -	Pins/Needles	O O O O
Pain	x x x x	Stabbing	vvvvv



Front



Back

Section 5: Functional Status:

□ yes □ no Do you have trouble getting to sleep because of pain. If yes please explain.

_____

_____

□ yes □ no Do you exercise? If yes, how often _____

Section 6: Please list all medications you **currently** take for **any reason** (including non-prescription drugs).

Drug Name	Dose	How Often	Pain meds only- -	Does it help?
			□ yes □ no	□ don't know
			□ yes □ no	□ don't know
			□ yes □ no	□ don't know
			□ yes □ no	□ don't know
			□ yes □ no	□ don't know
			□ yes □ no	□ don't know
			□ yes □ no	□ don't know

Please lists all known allergies:-_____

Section 7: Please list any changes in Medical Health History or any recent hospitalizations or doctors visits:

_____

_____

Section 8: Review of Systems:

Check all that apply: □ None apply

□ Reading glasses	□ Abnormal heartbeat	□ Frequent Constipation	□ Hot or cold spells
□ Change of Vision	□ Swollen ankles	□ Hemorrhoids	□ Recent wt. change
□ Loss of hearing	□ Calf cramps w/walking	□ Frequent urination	□ Nervous exhaustion
□ Ear pain	□ Poor appetite	□ Burning on urination	*Women only*
□ Hoarseness	□ Tooth ache	□ Difficulty starting urination	□ Irregular periods
□ Nosebleeds	□ Gum trouble	□ Get up more than once every night to urinate	□ Vaginal disch
□ Difficulty swallowing	□ Nausea or vomiting		□ Freq. spotting
□ Morning cough	□ Stomach pain	□ Frequent headaches	□ Other
□ Shortness of breath	□ Ulcers	□ Blackouts	_____
□ Fever or chills	□ Frequent belching	□ Seizures	_____
□ Heart or chest pain	□ Frequent diarrhea	□ Frequent rash	_____

How well are you sleeping?

_____

_____

*MD Initials and date*_____

Name_____
Reg. No._____

For Physician use only:

Vital signs: WEIGHT: _____ BP: _____/_____ HEART RATE: _____

Examination:

Neurologic:

Sensation

Reflexes

others

MSK:

Inspection:

Strength

ROM

SPECIAL TESTS:

Other exam findings:

Assessment: (Please list objective findings if any)

Plan:

1.

2.

3.

4.

Please send cc to referring physician