Orlin & Cohen Medical Specialists Group

Patient Label

Sports Medicine, Joint Replacement, Arthroscopy & Reconstructive Surgery, Foot & Ankle Surgery,
Knee & Shoulder Reconstruction, Spinal Surgery & Pain Management, Hand & Elbow Surgery, Trauma

FOLLOW-UP/POST INJECTION/PAIN MANAGEMENT FORM

Work/Sports Status: Full Time / Part Time / Injured / Disabled / Student / Retired / Light Duty / Not working due to the Injury

Where is your pain today? ❑ Low Back ❑ Neck ❑ Right Leg ❑ Left Leg ❑ Right Arm ❑ Left Arm ❑ Mid-Back ❑ Upper Back ❑ Buttock ❑ Head ❑ Other_____

Does your pain radiate YES / NO? If yes, where_____

Quality: What type of pain do you have? ❑ Burning ❑ Diffuse ❑ Dull/Aching ❑ Localized ❑ Radiating ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Throbbing ❑ Tightness ❑ Tingling ❑ Squeezing ❑ Other_____

Does the pain affect your activity in these different areas? *Check all that apply*

❑ Household Chores ❑ Leisure ❑ Work ❑Sleep ❑ Sexual Activity ❑ Social Interactions ❑ Other_____

Pain at Rest: 0 –10_____ Pain at Activity: 0 –10_____

Is your pain ❑ Constant ❑ Intermittent ❑ Frequent ❑ Occasional

Does anything make your pain better? *Check all that apply* ❑ Rest ❑ Meds ❑ Bending/Leaning Forward ❑ Extending Back ❑ Ice ❑ Heat ❑ Sitting ❑ Standing ❑ Walking/activity ❑ Massage ❑ Physical Therapy ❑ Injection Therapy ❑ Nothing helps ❑ Other_____

Does anything make your pain worse? *Check all that apply* ❑ Sitting ❑ Standing ❑ Walking ❑ Bending Forward ❑ Extending Back ❑ Lifting ❑ Exercise ❑ Stairs ❑ Lying in bed ❑ Coughing ❑ Physical Therapy ❑ Other

Have you had any new tests or imaging studies for this problem? YES / NO

If yes, list facility, type & date: _____

Have you had physical therapy for this problem? YES / NO If yes, date: _____

Current Medications: (Include Doses and Frequency) _____

_____

List any side effects to medications: _____

_____

Height_____ Weight_____

REVIEW OF SYSTEMS: (Check All That Apply)

GENERAL
❑ Weight Change
❑ Fever or Chills
❑ AIDS/HIV
❑ Night Sweats
❑ Bleeding
❑ Lumps or Masses
❑ Dizziness or Fainting
❑ Diabetes Mellitus
❑ Thyroid Problem
❑ Cancer

MUSCULOSKELETAL
❑ Joint Pain
❑ Joint Swelling
❑ Back Pain
❑ Neck Pain

GASTROINTESTINAL
❑ Difficulty Swallowing
❑ Jaundice
❑ Hepatitis
❑ Reflux
❑ Ulcer

CARDIOVASCULAR
❑ Chest Pain
❑ Heart Disease
❑ High Blood Pressure
❑ Mitral Valve Prolapse
❑ Thrombophlebitis/DVT/PE

GENITOURINARY
❑ Urinary Infections
❑ Incontinence
❑ Urinary Frequency
❑ Venereal Disease
❑ Menopause

NEUROLOGIC
❑ Seizures
❑ Numbness
❑ Weakness

PSYCHOLOGICAL
❑ Depression
❑ Bipolar
❑ ADD/ADHD
❑ Other

EAR-EYES-NOSE-THROAT
❑ Visual Change
❑ Hearing Change
❑ Tinnitus
❑ Bleeding Gums

RESPIRATORY
❑ Cough/Sputum
❑ Tuberculosis
❑ Shortness of Breath
❑ Asthma
❑ Emphysema

SKIN
❑ Wound Discharge
❑ Itching or Rash

❑ All Systems Reviewed & Negative

Providers Notes Section:

Update Pharmacy Information

We can send your prescriptions directly to your pharmacy so that there is less waiting time for you. If you know your pharmacy, please complete the below form. Please be aware that the easiest way for us to find your pharmacy is to know the zip code.

Your Name:	Date of Birth:	
Pharmacy Name:		
Address:		
City:	State:	Zip:
Pharmacy Phone #:	Pharmacy Fax:	