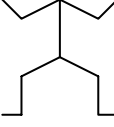


# H&P: Pain

		Name _____	
<b>Date</b> _____ <b>Age</b> _____		<b>Pain Hx</b> (onset, locations, descriptors, worse/better, treatments)	<b>ROS (circle positives)</b> Vision/hearing Lo energy Sleepy Dizzy/unsteady Syncope Falls Dry mouth Chest pain Ulcer/GERD Constipation Nausea Appetite Weight change Edema Night sweats Insomnia Depression Urine freq. Confusion Sex dysfxn
<b>Pain Disability (3=lot)</b> Walking _____ Pleasure act. _____ Shopping _____ Driving _____ Exercise _____ Bathing _____ Toilet/cont. _____ Thinking _____ Sleep _____ Appetite _____ Mood _____ Relationships _____ Energy _____ <b>Total (0-39)</b> _____		<b>Pain Diary Interpretation</b> (worst pain, med effects)	<b>Health Habits</b> Tobacco _____/pk-yrs. Street drugs?      Y N Alcohol _____/day Ever heavy?      Y N
<b>PMHX (circle positives)</b> Headache TMJ Dental Neck pain Dysphagia COPD Chest pain Cardiac problem GI problem GU problem Abdominal pain Pelvic/GU pain Arthritis Fibromyalgia Joint pain Back pain Hip/knee pain Muscle pain Diabetes Neurologic disorder Depression Anxiety Sleep problems		<b>Medications</b>	<b>Exercise History</b> Min/wk _____ What kind? _____
<b>Family History</b> <i>(circle positives)</i> Diabetes Arthritis Depression Anxiety Neurologic disorder		<b>Positives</b> (PMHx, ROS, others)	<b>Social Support</b> How much help? _____ Who helps? _____ Hired help?      Y N Enough money?    Y N

<b>Vital Signs</b>	<b>BP</b> _____	<b>P</b> _____	<b>T</b> _____	<b>Wt.</b> _____	<b>lb</b>	<b>Ht.</b> _____	<b>in</b>
<b>Eyes</b> <input type="checkbox"/> nl conjunctiva & lids Pupils <input type="checkbox"/> pupils symmetrical, reactive Fundus <input type="checkbox"/> nl discs & pos elements Vision <input type="checkbox"/> acuity and gross fields intact	<b>MS Gait</b> <input type="checkbox"/> nl Get Up and Go Test Extremities <input type="checkbox"/> no edema Check nl, circ abn      ROM      Strength      Tone      Sensory Right arm <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Left arm <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Right leg <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Left leg <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spine/back <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						
<b>ENT-External</b> <input type="checkbox"/> no scars, lesions, masses Otoscopic <input type="checkbox"/> nl canals & tympanic membranes Hearing <input type="checkbox"/> nl to _____ Intranasal <input type="checkbox"/> nl mucosa, septum, turbinate Ant. Oral <input type="checkbox"/> nl lips, teeth, gums Oropharynx <input type="checkbox"/> nl tongue, palate, pharynx	<b>Cognition</b> <input type="checkbox"/> normal screen. Test: _____ Attention <input type="checkbox"/> nl alertness, attentive Cranial nerves <input type="checkbox"/> w/o gross deficit Coordination <input type="checkbox"/> nl rapid alternating movement DTR's <input type="checkbox"/> symmetrical, ____ (scale: 0-4+) Sensation <input type="checkbox"/> nl touch, proprioception Mood <input type="checkbox"/> nl screen. GDS ____/15						
<b>Neck palp.</b> <input type="checkbox"/> symmetrical without masses Thyroid <input type="checkbox"/> no enlargement or tenderness JVD <input type="checkbox"/> None .v-srodiac							
<b>Resp. effort</b> <input type="checkbox"/> nl without retractions Chest percuss. <input type="checkbox"/> no dullness or hyperresonance Chest palp. <input type="checkbox"/> no fremitus Auscultation <input type="checkbox"/> nl bilateral breath sounds w/o rales	<b>Pain Body Area:</b> _____ Inspection: Palpation: Strength: Sensation: Function:						
<b>Heart palp.</b> <input type="checkbox"/> nl location, size Cardiac ausc. <input type="checkbox"/> no murmur, gallop, or rub Carotids <input type="checkbox"/> nl intensity w/o bruit Pedal pulses <input type="checkbox"/> nl posterior tibial & dorsalis pedis	<b>Breasts</b> <input type="checkbox"/> nl inspection & palpation						
<b>Abdomen</b> <input type="checkbox"/> no masses or tenderness L/S <input type="checkbox"/> no liver/spleen enlargement Hernia <input type="checkbox"/> no hernia identified Anus/rectal <input type="checkbox"/> no abnormality or masses	<b>GU male</b> <input type="checkbox"/> nl inspection & palpation Prostate <input type="checkbox"/> nl size w/o nodularity						
<b>GU female</b> <input type="checkbox"/> external genitalia nl w/o lesions Int. inspection <input type="checkbox"/> nl bladder, urethra, & vagina Cervix <input type="checkbox"/> nl appearance w/o discharge Uterus <input type="checkbox"/> nl size, position, w/o tenderness Adnexa <input type="checkbox"/> no masses or tenderness	<b>Lymphatic</b> <input type="checkbox"/> nl neck & axillae Lymph other <input type="checkbox"/>						
<b>Additional Description of Positive Findings</b>							

**Assessment**

**Plan**

**Educational Materials**

*(check those given)*

- Evaluation and Management of Persistent Pain
- How to Complete the Daily Pain Diary
- Using Medications for Persistent Pain
- Living Well with Persistent Pain
- Exercising with Persistent Pain
- How to Stretch
- NSAIDs
- Opioids and Persistent Pain
- Depression Medications for Persistent Pain
- Managing Constipation
- Treating Pain without Pain Pills
- Pain Care: Bill of Rights