McLaren Flint
Flint, MI

SURGERY AND ENDOSCOPY CENTER PAIN CLINIC
HISTORY AND PHYSICAL

______year old ☐ Male ☐ Female Chief Compliant:____
Presenting for: ☐ Initial Visit ☐ Return Visit ☐ Post-procedural Evaluation
Procedure Performed: ____ Date:____________
Pain relief after procedure: __________________________Duration:______________________
Functioning/Activity: ______________________________ Sleep:_________________________
New Issues:____

Allergies:	Past Medical/Surgical History:
Current Pain Medications:	

Physician Review of Symptoms:

☐Anemia	☐Vomiting	☐Headache	☐Hearing Problems	☐Sexual Difficulty
☐Edema	☐Constipation	☐Seizures	☐Vision Problems	☐Difficulty Swallowing
☐Fatigue	☐Weight Gain	☐Depression	☐Urinary Problems	☐Chronic Fatigue
☐Chest Pain	☐Weight Loss	☐Bleeding Disorder	☐Dizziness	☐Fall
☐Shortness of Breath	☐Jaundice	☐Fracture: Leg or Arm	☐Rashes	☐Balance Problems
☐Nausea	☐Confusion	☐Memory Problems	☐Poor Sleep	

Other:

Physical Examination: BP:_______ Pulse:_______ RR:______ Temp:______ Pulse Ox:_______ % at Room Air _______

Mood /Affect:
☐Pleasant ☐Depressed ☐ Flat ☐Appropriate Conversation
Appearance:
☐Normal ☐Fatigue ☐ Distressed
Respiratory:
☐ CTA ☐Unlabored ☐Not in use of accessary muscle ☐Rales
CVS:
☐RRR ☐ S1/S2 ☐Abnormal sounds ☐Varicosities
☐Pedal pulses x4 ☐ No edema
Abdomen:
☐Soft ☐Non-tender ☐Firm ☐Bowel sound audible x4 ☐Distention
Gait:
☐WNL ☐Antalgic ☐Walks with stiff/flat back
CNS:
☐No focal neurological defects ☐Cranial II-XII intact
Sensation: ___________ to light touch at UE/LE
☐Bilateral ☐Right ☐Left

Muscle Strength : Lower Extremity, UpperExtremity:
____
Cervical/Thoracic/Lumbar Paraverterbral Muscle:
☐Tender in palpation ☐Bilateral ☐Right ☐Left ☐Non-tender
Lumbar Facet Loading Test:
☐Negative ☐Positive ☐Bilateral ☐Right ☐Left
Palpation over Sacroiliac Joint:
☐Non-tender ☐Tender ☐Bilateral ☐Right ☐Left
Patrick/FABER Test:
☐Negative ☐Positive ☐Bilateral ☐Right ☐Left
Spurling Sign:
☐Negative ☐Positive ☐Bilateral ☐Right ☐Left
Others:

DTR	Biceps	Triceps	Brachio-radialis	Patella	Achilles	Plantar	P=Pain R=Releif	Flexion	Extension	Twist	Side Bend
Right							Cervical				
Left							Lumber				

Diagnosis/Findings: 1. ______________________________ **2.** ______________________________
3. ______________________________ **4.** ______________________________

Plans:
1. Pharmacologic: Rx Refilled ☐ ________________________ 2. Consultations:________________________
3. Counseling:________________________________ 4. Interventional:________________________
5. Follow Up:________________________________ ☐MAPS Reviewed ☐ UDS ordered/ reviewed

Physician Signature:____**Date & Time:** ______________

PT.

MR.#/P.M.

DR.

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