NEW JERSEY SPINE AND PAIN INSITUTE, LLC

Joseph G.A. Ibrahim, MD, FAAPMR
Interventional Spine and pain Management
Diplomate American Board of Physical Medicine and Rehabilition
Diplomate American Board of Pain Medicine

Hospital affliation:
Saint Clare's Health system, Denville,NJ
Chrit Hospital, Jersey City, NJ
Bayonne Medical Center, Bayonne, NJ

FOLLOW UP VISIT DOCUMENTATION

Patient Name _____ **Date** _____

PRIMARY PHYSICIAN_____ Phone _____

1. Describe your main pain problem:

_____

_____

2. Did you have any injections on your last visit? Yes No **Circle all that apply:**
Epidural Sacral Joint Facet Joint Trigger Point Other procedure
How much relief from the procedure you had done?
0%_____ _____ _____ _____ 50% _____ _____ _____ _____ 100%

3. Were any medications started on your last visit? Yes No Complete:

Name	Dosage	Time per day
_____	_____	_____
_____	_____	_____

4. Were any medication dosages changed on last visit? Yes No **Complete:**

Name	Old Dosage	New Dosage	Time per day
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Please LIST ALL of your current pain medications and the doctors that prescribe them including medications given by another physicians.
DO NOT WRITE "SAME AS BEFORE"

Name	Dosage	Time per day	Prescribing doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have your symptoms been helped, is there any change in your activities? Explain.

_____

_____

6. Rate Relief:
0%_____ _____ _____ _____ 50% _____ _____ _____ _____ 100%

19 East 27th Street
Bayonne, NJ 07002

Phone #201-436-0033
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7. for your own health and safety, PLEASE List all changes of the medications you are taking, including non-prescription: DO NOT WRITE "SAME AS BEFORE"

Name	Dosage	Time per day

Please circle any conditions you have experienced since your last appointment:
Chills, night sweats, fever, easy bleeding, rash, bruising, recent changes in vision, smell, hearing or taste, dizziness, shortness of breath, sputum, wheezing, cough, chest pain, feet swelling, palpitations, nausea, diarrhea, indigestion, bloody or dark stools, vomiting, abdominal pain, unable to control bowel or bladder, rushing to urinate, frequent urination, muscle cramps, joint pain/swelling, attack of weakness, morning stiffness, poor appetite, numbness/tingling in feet, crying spells, numbness/tingling in hands, convulsions, headache.

Circle the numbers below that best describe how pain has interfered with your daily functioning this past week.

	0= Does not interfere									10= Completely interferes
General Activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Normal Work Routine	0	1	2	3	4	5	6	7	8	9	10
Relations With Other People	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

8. Please List any side effect that you may feel related to your pain medications

_____
_____
_____
_____

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