

Patient Name: _____ Date: _____

Follow-up Office Visit for Chronic Opioid Analgesia

Patient maintained on _____

Breakthrough pain meds _____

Side effects: None Nausea Emesis Confusion Somnolence Fatigue Constipation
 Other _____

Constipation controlled by _____ Benefit from meds: (Yes No)

C/O: _____

Pain Scale Rating: 0 1 2 3 4 5 6 7 8 9 10 Previously rated: 0 1 2 3 4 5 6 7 8 9 10

Change in Medical History: No Yes, _____

Change in ROS: No Yes, _____

Reviewed previous notes including History & Physical Reviewed previous radiological reports

Notes: _____

Physical Exam: BP _____ HR _____ RR _____ SaO2 on room air _____.

HEENT: Pupils: _____ mm Response to Light: (Reactive Min. Reactive Nonreactive)

Heart: RRR irregularity _____ Lungs: CTAP _____

Notes: _____

Impression: 1. _____

2. _____

3. _____

4. _____

Plan/Discussion: _____

