Name:_____ **Date:**_____ **Age:**_____

Pain Level without medication_____**/10**

With medication_____**/10**

Side effects ( ) Lightheadedness

( ) Constipation

( ) Itching

( ) Urinary Retention

( ) Pain relief allows the performance of self care

( ) Pain relief allows the performance of household chores

( ) Pain relief allows the performance of leisure activities

( ) Pain relief not enough to allow the performance of work

Your weight: _____ **Height:**_____

Which body part is the Doctor treating? _____

What is the problem(swelling, pain, weakness, etc.) _____

List any NEW drug allergies _____

List any NEW medications from any other Doctor _____

List what medication(s) you are here for today _____