Lido Chen M.D., INC.
23521 Paseo De Valencia, Laguna Hills, CA 92653

Name:____________________________ Date: __________________

Mark your main areas of pain:

O head	O lower back	O groin
O jaw	O abdomen	O hip
O neck	O pelvic	O leg
O shoulder	O chest	O knee
O upper back	O arm	O ankle
O mid back	O hand	O foot

Is this your regular visit? Mark all that apply:

O Yes, it is my regular visit	O for medication only
O for injection only	O for medication and injection
O due to increased pain	O for evaluation
O running out of medication too early	

Do you have any new pain symptoms since your last visit?
O Yes O No

Do you have any of the following side effects to medication?

O nausea/vomiting	O leg edema	
O constipation	O dry mouth	
O confusion	O sedation	
O dizziness	O sweating	O other: __________________
O slurring	O itching	O none

Select all life improvements from treatment:

O Daily activity	O emotion
O social activity	O sleep
O work tolerance	O others: _________________________
O relationship	O none
O energy	

Any change in health status from last visit?
O Yes O No (Please explain) ___________________________________

Any changes in your medication since your last visit?
O Yes O No (Please Explain) ___________________________________

ROS:

Constitutional

Weight gain	O Yes	O No
Weight loss	O Yes	O No
Fatigue	O Yes	O No
Sweating	O Yes	O No
Insomnia	O Yes	O No
Excessive sleep	O Yes	O No
Fever	O Yes	O No
Dizziness	O Yes	O No
Weakness	O Yes	O No
Loss of appetite	O Yes	O No

Compliance of Medication

Do you take all medications as prescribed? O Yes O No
Do you allow others access to your medication? O Yes O No
Do you keep your medication locked ? O Yes O No

Do you get any scheduled/controlled substances from any other provider? O Yes O No

Do you use any street drug? O Yes O No

Do you feel unable to control how you take your medication?
O Yes O No

Psychology

Are you seeing Psychiatrist? O Yes O No
Are you receiving counseling? O Yes O No
Do you have panic/anxiety attacks O Yes O No
Do you have suicidal thoughts? O Yes O No

Do you have any of the following symptoms?
O sadness O loss of concentration
O isolating self O lack of energy
O lack of interest in usual activities O none of these

Neurology

Have you experienced any numbness? O Yes O No
Have you experienced any tingling? O Yes O No
Have you had any episodes of confusion? O Yes O No
Have you had any episodes of lost time? O Yes O No

Have there been any amnesic events or activity you don't remember?
O Yes O No

Do you feel that your medication affects your ability to drive or operate any motor vehicle? O Yes O No

Level of pain (0 least, 10 worst)

without pain medication
O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

with pain medication
O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

with increased activity
O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

during sleep
O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Please list all medications prescribed by DR. Chen:

Name of medication & strength	How are you taking them?	Do you need a prescription today?
______________________	______________________	O Yes O No
______________________	______________________	O Yes O No
______________________	______________________	O Yes O No
______________________	______________________	O Yes O No
______________________	______________________	O Yes O No
______________________	______________________	O Yes O No
______________________	______________________	O Yes O No
______________________	______________________	O Yes O No