Please initial, date, sign

PATIENT MEDICATION AGREEMENT

for Painkillers, Anxiety Medication, Stimulants, and all Controlled Substances

You are being prescribed a medicine that has many risks. The medicine also has special laws that the doctor and patient must follow.

It is important that you follow all these instructions, EXACTLY.

- ☐ **These medicines are dangerous. They can cause serious health problems, including death, even if taken as prescribed. They are also addicting.**
- ☐ **You should get your medicine from only ONE provider and ONE pharmacy. This helps prevent side effects and overdoses.**
- ☐ **Take the medication only as you are told. Do not take more medicine than you are prescribed. They need to last you until your next appointment.**
- ☐ **Your medicine is only for you. Do not share your medicine. Do not allow others to use your medicines. Do not sell or trade your medicines.**
- ☐ **Keep your medications secure. We recommend locking them. Lost or stolen medication means other are in danger.**
- ☐ **All emergency departments in San Diego and Imperial Counties have stated that they will not prescribe these medications if you lose them or feel you need more.**
- ☐ **The dangers of the medicine are greater with anything that makes you sleepy. Mixing your medicine with alcohol, street drugs, sleeping pills, or other drugs can make you sick or die.**
- ☐ **Do not drive a car or do dangerous activities if you are not fully alert when on these medicines.**
- ☐ **Your treatment will be monitored in different ways. You may be asked to do a drug test. You may be asked to show your pills. The State of California tracks your prescriptions.**
- ☐ **If your provider feels that your medicine is not helping, the medicine will be stopped. You will be treated with other methods.**

Date: _____

Sign: _____

HHSA LIVE WELL

Imperial County California Public Health Department

Imperial County Medical Society

San Diego County Medical Society
"Physicians United for a Healthy San Diego"

Hospital Association of San Diego and Imperial Counties
Advocates for Access to Health Care for All Californians

Comprehensive Pain Management Group
Return Visit Questionnaire

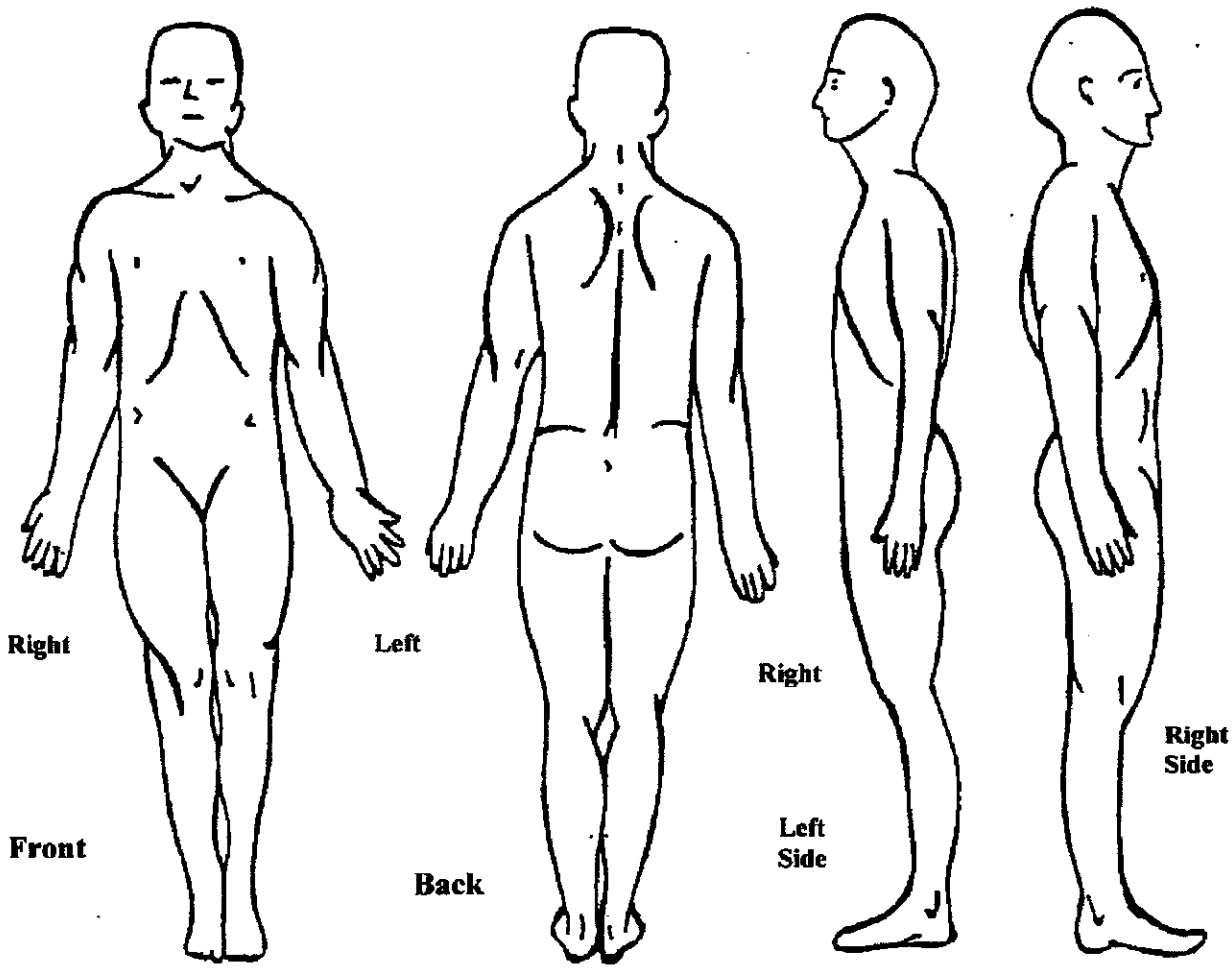
Name: _____

Visit Date: _____

Reviewed with patient by: _____ **Date:** _____

I. LOCATION:

A. Shade in the areas of your body that have pain in **red**, *and numbness in* **blue**.
B. Place "X1" next to area of greatest pain.
C. Place "X2" next to area of second greatest pain. For office use: BP: HR: O2 sat:



II. Intensity: VAS Pain Rating Scale

1. a. Rate your **current** feelings of pain on the scale.
(0 is **no pain** and 10 is the **worst** pain you can imagine.)

0 1 2 3 4 5 6 7 8 9 10

No pain ← → Worst possible pain

b. Rate your pain when you are at rest and when you move. (0 - 10)

Rest pain score: _____ Movement pain score: _____

2 **Activities of Daily Living**
(Please check the box for Better, Same or Worse for each item below.)

		Better	Same	Worse
a.	Physical Functioning	☐	☐	☐
b.	Family Relationships	☐	☐	☐
c.	Social Relationships	☐	☐	☐
d.	Mood	☐	☐	☐
e.	Sleep Patterns	☐	☐	☐
f.	Overall Functioning	☐	☐	☐

3 Since your last visit have you returned to work? Yes ☐ No ☐
If you had injection, did it make improvement in your pain? Yes ☐ No ☐

4 Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life? Yes ☐ No ☐

5 If physical therapy has been a part of your treatment plan:
a. How many sessions have you had? _____
b. Have you missed any sessions? Yes ☐ No ☐
c. If yes, what reason? _____

6 If health psychology has been a part of your treatment plan:
a. How many sessions have you had? _____
b. Have you missed any sessions? Yes ☐ No ☐
c. If yes, what reason? _____

7 Please restate your goals regarding your pain management with us:

_____

8 What goals have you met since your treatment with us?

_____

9 Pattern of pain: *(Please check appropriate)*

What is the frequency of your pain? Constant ☐ Frequent ☐ Occasional ☐
% Time Pain-Free? _____

Does the pain change during the day? Yes ☐ No ☐
If yes, what time of the day is your pain worst? Morning ☐ Afternoon ☐ Night ☐
What part of the day is the pain better? Morning ☐ Afternoon ☐ Night ☐
How many episodes of pain do you have? Per day _____ Per week _____
Duration of episodes: Few minutes ☐ Several hours ☐ Several days ☐

10 Quality of your pain: *(Please check appropriate)*
Burning ☐ Stabbing/Sharp ☐ Dull, Diffused ☐ Cramping/Spasms ☐
Throbbing ☐ Tingling ☐ Numbness ☐ Other _____

11 What areas of pain have improved? _____

12 What areas of pain have stayed the same? _____

13 What areas of pain have gotten worse? _____

14 Any new accidents or falls since your last visit? _____

15 Are you pregnant? Yes ☐ No ☐

16 **Adverse Events:**

Are there any potential side effects from the medications you are taking? *Please check appropriate*

		None	Mild	Moderate	Severe
a.	Nausea	☐	☐	☐	☐
b.	Vomitting	☐	☐	☐	☐
c.	Constipation	☐	☐	☐	☐
d.	Itching	☐	☐	☐	☐
e.	Mental Cloudiness	☐	☐	☐	☐
f.	Sweating	☐	☐	☐	☐
g.	Fatigue	☐	☐	☐	☐
h.	Drowsiness	☐	☐	☐	☐
i.	Other _____	☐	☐	☐	☐

17 Please list all **current** medications:
(Including any **over the counter medications** and **physician prescriptions**)

Name of medication	Dose	Total daily dose	Prescriber

LARS R. NEWSOME, MD
ASMG
Pain Management Office | 4130 La Jolla Village Drive, Suite 300 | La Jolla, CA 92037

DRIVING INSTRUCTIONS FOR PATIENTS TAKING OPIOIDS

Opioid medications can cause side effects that impair your ability to drive. The final decision on whether you should drive while using opioid medications is a legal issue and should be addressed with your automobile insurance carrier. Out of concern for your safety and the safety of others, please observe the following guidelines:

- **Do not drive for 4 – 5 days after beginning opioid treatment or after a change in opioid treatment such as a dose increase.**
- **Do not drive if you ever feel sedated or cognitively impaired.**
- **Report sedation/unsteadiness/cognitive decline to our office as soon as possible.**
- **Under no circumstances should you use alcohol or illicit drugs such as cannabis (marijuana) and drive.**
- **Avoid taking over-the-counter antihistamines, as contained in numerous cold and allergy medications.**
- **Do not make any changes in your medication regimen without consulting our office.**

Patient Name	
Patient Signature	Date
Practitioner Signature	Date

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
	TOTAL		_____	_____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005;6(6):432-442. Used with permission.

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EPWORTH SLEEPINESS SCALE

Date:

Name:

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

0 Would never doze
1 Slight chance of dozing
2 Moderate chance of dozing
3 High chance of dozing

Situation	Change of Dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without	
In a car, while stopped for a few minutes in the traffic	
Total	

SCORING
0-10 Normal range
10-12 Borderline
12-24 Abnormal