What problems would you like to discuss at today's visit?

Do you need any refills on your medications today?

What was your **average level** of pain in the past month (on a scale of 1 to 10)	
What was your most **best** level of pain in the past month (on a scale of 1 to 10)	

Please answer the following questions as honestly as possible. Over the past month have you:

Been able to prepare meals for yourself?	Yes	No
Been able to carry out your household chores?	Yes	No
Been able to take care of yourself (brush your teeth, bath, dress)?	Yes	No
Work outside the home at a job?	Yes	No
Had trouble with constipation?	Yes	No
Had nausea or vomiting?	Yes	No
Had trouble remembering things or concentrating?	Yes	No
Been overly tired due to your medications?	Yes	No
Lost or misplaced your pain medication?	Yes	No
Used more than one pharmacy to fill your pain prescriptions?	Yes	No
Received pain prescriptions from more than one provider?	Yes	No
Taken your pain medication other than the way they were prescribed?	Yes	No
Borrowed pain medication from others?	Yes	No
Run out of your pain medication early?	Yes	No
Used any illegal substances?	Yes	No
Missed any scheduled medical appointments?	Yes	No
Have you been overly depressed in the past month?	Yes	No
Have you been overly anxious in the past month?	Yes	No

Please check-off any problems you have had in the past MONTH:

	Excessive fatigue
	Significant weight loss
	Significant weight gain
	Sores on your feet
	Blurred vision
	Shortness of breath
	Chest pain lasting more than seconds
	Swelling of feet or ankles
	Hypoglycemic (low sugar) episodes
	Trouble feeling things in your feet