University of Maryland Medical Center
Acute Pain Management Service

Pain Consultation

<table>
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<tr>
<th>PATIENT NAME</th>
<th>AGE</th>
<th>DATE</th>
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**DIAGNOSIS / INJURIES**


**PMH**


**PREVIOUS SURGERIES / TX'S FOR PAIN**


**CURRENT ANALGESIC REGIMENTS / MEDICATIONS**


**LOCATION OF PAIN**


**PAIN INTENSITY: PPI**

(0) NO PAIN  (1) MILD  (2) DISCOMFORTING  (3) DISTRESSING  (4) HORRIBLE  (5) EXCRUCIATING

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**PAIN CHARACTER (USE PATIENT'S OWN WORDS, E.G. ACHE, BURN, THROB, CUTTING)**


**SUBSTANCE ABUSE HISTORY**

SMOKE YES NO

UNKNOWN HOW MUCH?

OTHER DRUGS YES NO

UNKNOWN LIST

**ALCOHOL YES NO**

UNKNOWN HOW MUCH?

**SUBSTANCE ABUSE CONFLICTATION YES NO**

**SLEEP DISTURBANCE YES NO**

**IS PATIENT ABLE TO SLEEP AT NIGHT YES NO**

**KEEPING THEM AWAKE AT NIGHT? YES NO**

**PHYSICAL EXAM**


**IMPRESSION**


**PLAN**


**SIGNATURE**


**VAS = VISUAL ANALOG SCALE**

**PPI = PRESENT PAIN INDEX**

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