Taking Care of My Pain Management

A guide for you or your caregiver to be active in either your own health care or caring for someone else.

Visit With: ____________________________  Today's Date: ____________________________

BE SURE YOU KNOW THESE THINGS:

1. I am meeting with a health care provider today because:
   ________________________________________________________________

2. What medical conditions I feel are related to this visit ________________
   ________________________________________________________________

3. What other healthcare providers have I seen since my last visit with this provider?
   ________________________________________________________________

4. What healthcare providers am I now seeing for my pain problem?
   ________________________________________________________________

5. Have my medication changed since my last visit to this provider?
   ________________________________________________________________

6. List all the medicines (on page 2) I am taking, including all on the following list?
   ____ Prescription medicine (can buy only with a prescription)
   ____ Over-the-counter medicine (can buy without a prescription)
   ____ Vitamins, herbs, or supplements I take (such as St. John’s Wort)
   ____ Any NEW prescriptions I received during this visit
   ____ Written directions on how to take all my medicines
   ____ Major side effects of these medicines

7. Besides taking my medicines, what else do I need to do?
   ____ Get blood tests or other medical tests?
   ____ Get extra help or equipment at home?
   ____ Avoid caffeine, alcohol, tobacco, or other drugs?
   ____ Avoid eating certain foods?
   ____ Eat certain foods?
   ____ Change a bandage?
   ____ Exercise?
   ____ Schedule a follow up appointment?
   ________________________________________________________________

8. My pain level today is a mild, moderate, severe, worst possible pain
   (Circle One)
   ____ How much pain is necessary to justify the use of opioids?

9. What prescription medications am I currently taking to relieve my pain?
   ________________________________________________________________

10. Are any of these medication considered an opioid? If so, are there other non-opioid
    alternatives or alternative treatments to opioids for pain management we can consider?

11. What medication side effects should I be aware of? What are the signs of opioid
    addiction?
    ________________________________________________________________

12. Do I need a referral to other health care providers, tests or facilities? If so, Why?
    ________________________________________________________________

13. Who should I call before my next appointment if I have questions or concerns
    In managing my pain?
    ________________________________________________________________

NAME: ____________________________  TELEPHONE #: ____________________________

Be sure to tell your Provider of any allergies or sensitivities you have to any medicine.
**MY MEDICINE**

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<thead>
<tr>
<th>WHEN I GET UP, I TAKE:</th>
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<tbody>
<tr>
<td>Drug name-Brand name or generic &amp; DOSE:</td>
<td>This looks like: (Color, shape, etc)</td>
<td>How many?</td>
<td>How I take it:</td>
<td>I started taking this on: (date)</td>
<td>I stop taking this on: (date)</td>
<td>Why I take it:</td>
<td>Who told me to take it? (name)</td>
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<td>Example: Lisinopril 10 mg</td>
<td>Round yellow pill</td>
<td>1 pill</td>
<td>By mouth with breakfast</td>
<td>June 3, 2008</td>
<td>Keep taking</td>
<td>High blood pressure</td>
<td>Dr. Smith</td>
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<td>IN THE AFTERNOON, I TAKE:</td>
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<td>IN THE EVENING, I TAKE:</td>
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<td>BEFORE I GO TO BED, I TAKE:</td>
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<td>OTHER MEDICINES THAT I DO NOT USE EVERYDAY:</td>
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Questions to ask about taking your prescribed opioids:

1. When do I know it is time to transition off opioid medications to another treatment for my pain?
2. How should I change medication options?
3. How will I dispose of my unused Opioid prescription if prescribed?
4. How should I store my opioid prescription?