WM BREASTCARE
WEIRTON MEDICAL CENTER

Dear Patient

In an attempt to serve you better at Weirton Medical Center, please complete the below information.

Pain Screening	Yes	No
• Do you have pain today?	_____	_____
• Where is your pain located?	_____	
• How long have you had the pain?	_____	
• What have you done to make your pain go away?	_____	
• Rate your pain on a (0-10) scale with 10 being the worst pain	_____	

Functional Screening	Yes	No
Have you thought about hurting yourself within the last few months?	_____	_____
Has someone hurt you recently or in the last year?	_____	_____
Have you had a change in your appetite/nausea/vomiting/diarrhea recently?	_____	_____
Have you had a recent decline with walking or performing your daily activities?	_____	_____
Do you need help with finances, transportation or basic care?	_____	_____

Education

Do you need education on any of the following?

Medication	Yes	No
Equipment or Supplies	Yes	No
Pain Management	Yes	No
Treatment Plan	Yes	No
Nutrition	Yes	No
Rehabilitation	Yes	No
Health Practices or Safety	Yes	No
Oral Hygiene	Yes	No

Birthdate_____

_____ _____ _____
Patient Signature Date Time

_____ _____ _____
Information Reviewed by Date Time

Comments/Followup

_____
_____
_____
_____