

Follow-up Medical Questionnaire (Black Ink Only)

Appointment Date: _____ Chart# _____ Provider _____

Patient Name: _____ Reason for visit: f/u visit f/u FX Post-op

What body part is involved? (Please mark the table below)

(CC/Location)

<input type="checkbox"/> R arm <input type="checkbox"/> L arm <input type="checkbox"/> Neither	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Back – and radiates to: <input type="checkbox"/> R leg <input type="checkbox"/> L leg <input type="checkbox"/> Neither	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger: T 2 3 4 5 <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe: B 2 3 4 5 <input type="checkbox"/> R <input type="checkbox"/> L

- 1) Is there a new problem that was not evaluated at your last visit? Y N If Yes, what is it? _____
- 2) How long has it been since your last visit? _____ Days Weeks Months
- * 3) Since your last visit, are you: Better Worse Same (Context)
- 4) On a scale of 0 – 100%, how much better are you now? (If no better put 0%) _____ %
- * 5) On a scale of 0 – 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10 (Severity)
- * 6) What is the **quality** of the pain? Sharp Dull Stabbing Throbbing Aching Burning
- * 7) The pain is now: Constant Comes and goes (intermittent). Does your pain wake you from your sleep? Y N
- * 8) Do you have: Numbness Tingling Weakness Swelling Locking / Catching Giving Way
 Loss of control of bowel or bladder None (Assoc Symps)
- 9) What medications are you still taking for this condition: None Anti-Inflammatory _____ (Name)
 Narcotic (pain killer) _____ (Name)
- * 10) Use check box below to show what treatment was done at or since your last visit: (modify)

Treatment

Did it help?

- | | |
|--|---|
| <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Narcotics | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Brace/Cast | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Physical/ Occupational Therapy | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Injection at last visit: short-term | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Injection at last visit: long-term | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Surgery since last visit | <input type="checkbox"/> Y <input type="checkbox"/> N |

INTERVAL HISTORY: Since the last visit, have you:

- ***ROS** • Developed new problems in : Eyes Y N Heart Y N Bowels Y N Skin Y N
 Ears Y N Lungs Y N Urine Y N Diabetes Y N
 Nerves Y N Joints Y N None

Please describe any new problem: _____

- Developed new allergies? Y N If yes, please describe: _____
- ***PMH** • Been prescribed new medications by any other physician? Y N If Yes, please describe: _____
- Been hospitalized for a non-orthopedic condition? Y N If Yes, please describe: _____
- ***SH** • Started or stopped smoking? Y N If Yes, please describe: _____

What is your current job status? regular job light duty not working due to this condition do not work

Are there any questions you want the Doctor to answer for you at this visit? _____

Patient Signature: _____ MD/PA Signature _____ Date _____