

Office Use Only: Account # _____ Date: _____
 Height: _____ Weight: _____ BP: _____ Pulse: _____ M.A. Initials: _____

Follow-up Medical Questionnaire (Please Print)

Patient Name: _____ Appointment Date: _____ with Dr. _____

DOB: _____ Age: _____ Sex: F M Occupation: _____

Date of onset for current problem: _____ Primary Physician: _____

CHIEF COMPLAINT: Reason for visit: follow-up visit follow-up fracture post-op

What body part is involved? (Please mark the table below.) Date of surgery: _____

| | | | | | | |
|---|---|--|---|---|--|--|
| Neck- and radiates to <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 Toe: B 2 3 4 5 <input type="checkbox"/> R <input type="checkbox"/> L |
| 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 | Other _____ _____ |

HISTORY OF PRESENT ILLNESS:

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

4. On a scale of 0 – 100%, how much better are you now? (If not 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

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

REVIEW OF SYSTEMS: 8. Do you have: Numbness Tingling Weakness Swelling

Locking/Catching Giving Way Loss of control of bowel or bladder Fever Chills Sweats

Chest pain Shortness of breath None

9. Current medications: _____ None

10. Use check box below to show what treatment was done at or since your last visit:

| Treatment | Did it help? | X-rays since last visit? <input type="checkbox"/> Y <input type="checkbox"/> N if yes: |
|--|---|---|
| <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> Y <input type="checkbox"/> N | Body Part(s): _____ |
| <input type="checkbox"/> Narcotics | <input type="checkbox"/> Y <input type="checkbox"/> N | Date(s): _____ |
| <input type="checkbox"/> Brace/Cast | <input type="checkbox"/> Y <input type="checkbox"/> N | Facility Location(s): _____ |
| <input type="checkbox"/> Physical/Occupational Therapy | <input type="checkbox"/> Y <input type="checkbox"/> N | _____ times per week with _____ |
| <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Y <input type="checkbox"/> N | (therapy office) |
| <input type="checkbox"/> Injection at last visit: Short-term | <input type="checkbox"/> Y <input type="checkbox"/> N | Physical Therapy Start / Stop date(s): _____ |
| <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 your last visit, have you developed new problems in:

Eyes Y N Heart Y N Skin Y N Bowels Y N Joints Y N

Ears Y N Lungs Y N Nerves Y N Urine Y N Diabetes Y N

Describe any new problem(s): _____

Been hospitalized for a non-orthopaedic condition? Y N If yes, please describe: _____

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

LIST ALLERGIES: _____

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

Patient Signature: _____ MD/PA Signature: _____ Date: _____