Follow-up Medical Questionnaire
(Blank 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)

☐ R arm ☐ L arm ☐ Neither	Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Hand ☐ R ☐ L	Pelvis ☐ R ☐ L	Knee ☐ R ☐ L	Foot ☐ R ☐ L
☐ Back –and **radiates** to: ☐ R leg ☐ L leg ☐ Neither	Arm ☐ R ☐ L	Wrist ☐ R ☐ L	Finger: T 2 3 4 5 ☐ R ☐ L	Hip ☐ R ☐ L	Ankle ☐ R ☐ L	Toe: B 2 3 4 5 ☐ R ☐ 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
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
*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
9) What medications are you still taking for this condition? ☐ None ☐ Anti-inflammatory ______________________(Name)
☐ Narcotic (pain killer) ____________________(Name)
*10) Use the check box below to show what treatment was done at or since your last visit:

Treatment	**Did it help?**
☐ Anti-Inflammatories	☐ Y ☐ N
☐ Narcotics	☐ Y ☐ N
☐ Brace/Cast	☐ Y ☐ N
☐ Physical/Occupational Therapy	☐ Y ☐ N
☐ Home Exercise Program	☐ Y ☐ N
☐ Injection at last visit: short-term	☐ Y ☐ N
☐ Injection at last visit: long-term	☐ Y ☐ N
☐ Surgery since last visit	☐ Y ☐ N

INTERVAL HISTORY: Since the last visit, have you developed
***ROS** 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: ______________