Follow-up Medical Questionnaire (Please Print)

Appointment Date: _____ **Patient Name:** _____ **Date of Birth:** _____

Reason for Visit: ☐ **Follow-up Visit** ☐ **Follow-up Fracture** ☐ **Follow-up Operation Other:**

_____

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

☐ R arm ☐ L arm ☐ Neither ☐Back- and radiates to:	**Shoulder** ☐R ☐L	**Elbow** ☐R ☐L	**Hand** ☐ R ☐ L	**Pelvis** ☐ R ☐ L	**Knee** ☐R ☐L	**Foot** ☐ R ☐ L
☐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 – 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

5.) On a scale 0 – 100%, how much better are you now? (If no better put 0%) _____%

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 it wake you from 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 check box below to show what treatment was done at or since your last visit:

Treatment	**Did it Help?**
☐ Anti-inflammatories?	
☐ Narcotics	☐ Y ☐ N
☐ Braces/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:

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 ☐out of work due to this condition ☐do not work

Are there any questions you want to ask the Doctor? _____

_____

Signature Patient or Legal Guardian _____ **Date:** _____

Review by: Thomas J. Wall, M.D. _____Date: _____