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 ☐R arm ☐L arm ☐Neither	Shoulder ☐R ☐L	Elbow ☐R ☐L	Hand ☐R ☐L	Pelvis ☐R ☐L	Knee ☐R ☐L	Foot ☐R ☐L Toe: B 2 3 4 5 ☐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	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? ☐Y ☐N if yes:
☐ Anti-inflammatories	☐Y ☐N	Body Part(s):_____
☐ Narcotics	☐Y ☐N	Date(s):_____
☐ Brace/Cast	☐Y ☐N	Facility Location(s):_____
☐ Physical/Occupational Therapy	☐Y ☐N	___times per week with_____
☐ Home Exercise Program	☐Y ☐N	(therapy office)
☐ Injection at last visit: Short-term	☐Y ☐N	Physical Therapy Start / Stop date(s):_____
☐ Injection at last visit: Long-term	☐Y ☐N	
☐ Surgery since last visit	☐Y ☐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:_____