

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:

<b>Treatment</b>	<b>Did it help?</b>	<b>X-rays since last visit?</b> <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: \_\_\_\_\_