Follow-up Medical Questionnaire **SECOND PROBLEM**

Date: __________ Physician: ______________________

Patient name: ____

Reason for visit: ❒ F/U visit ❒ F/U fx ❒ Post-op
BP __/__ Pulse ____ Temp ___ SAO2_____(E5)

What body part are you following up for today? Please mark below and answer questions in regards to that problem. **If you have more than one problem – see receptionist**.

★ What body part is involved? One body part only:____(location)

If you have **more than one** - please see receptionist.

1) How long has it been since your last visit? _________ ❒ Days ❒ Weeks ❒ Months

★ 2) Since your last visit, are you: ❒ Better ❒ Worse ❒ Same (context)

3) On a scale of 0-100%, how much better are you now? If not better, put 0% __________%

★ 4) On a scale of 0-10 (10 is the worst) how severe is your pain now? (circle) 0 1 2 3 4 5 6 7 8 9 10 (severity)

★ 5) What is the pain **quality**? ❒Sharp ❒Dull ❒Sore ❒Swollen ❒Stabbing ❒Throbbing ❒Aching ❒Burning ❒No pain (quality)

★ 6) The pain is now ❒constant ❒comes and goes (intermittent) Does it wake you from sleep ❒Y ❒N (timing)

★ 7) Do you have ❒numbness ❒tingling ❒weakness ❒loss of control of bowel or bladder ❒none (assoc symps)

8) What medications are you still taking for this condition ❒none Anti-inflammatory _______________ (name)
Narcotic (pain killer) _____________ (name)

★ 9) Use the check boxes below to show what treatment was done at or since your last visit: (modify)

Treatment	Did it help?
❒ Anti-inflammatory Medications	❒ Y ❒ N
❒ Narcotics	❒ Y ❒ N
❒ Brace ❒ Cast ❒ Ice ❒ Heat	❒ Y ❒ N
❒ Physical Occupational or Massage Therapy	❒ Y ❒ N
❒ Home exercise program	❒ Y ❒ N
❒ Injection at last visit short term (_____ days)	❒ Y ❒ N
(____ weeks)	❒ Y ❒ N
❒ Surgery since last visit	❒ Y ❒ N

INTERVAL HISTORY: Since your last visit, have you						
ROS	● Developed any new problems in any of these areas? ❒ **I have had no new problems in these areas**	Allergies	Nerves	Lungs	Eyes	Skin
		Stomach/bowels	Other joints	Diabetes	Ears	Psychiatric
		Weight loss/fever	Heart	Urine	Anemia	
		Describe any problems:				
PMH	● Been prescribed **new** medications by another physician?	❒ Y ❒ N Describe:				
	● Been hospitalized for a non-orthopaedic condition?	❒ Y ❒ N Describe:				
SH	● Changed your prior smoking status?	❒ Y ❒ N Describe:				
	● What is your current job status?	❒ Regular job ❒ Light duty ❒ Not working due to this condition ❒ Do not work ❒ Retired				

Is there a new problem that was not evaluated at your last visit? ❒Y ❒N If so, what is it? ______________

Are there any questions you want the doctor to answer for you at this visit? ________________________

____

PRIMARY CARE PHYSICIAN____

Patient signature ___________________Date ________MD signature ______________________ Date______