

Follow-up Medical Questionnaire

Orthopaedic Surgery

Date: _____ Physician: _____

Reason for visit: <input type="checkbox"/> F/U visit <input type="checkbox"/> F/U fx <input type="checkbox"/> Post-op
BP ___/___ Pulse _____ Temp ___ SAO2 _____ (E5)

Patient name: _____

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) Is there are chance you may be pregnant? Y N

9) What medications are you still taking for this condition none Anti-inflammatory _____ (name)

Narcotic (pain killer) _____ (name)

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

Treatment	Did it help?
<input type="checkbox"/> Anti-inflammatory Medications	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Narcotics	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Brace <input type="checkbox"/> Cast <input type="checkbox"/> Ice <input type="checkbox"/> Heat	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Physical, Occupational or Massage Therapy	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Home exercise program	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Injection at <u>last</u> visit short term (____ days)	<input type="checkbox"/> Y <input type="checkbox"/> N
(____ weeks)	<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

ROS ● Developed any new problems in any of these areas? <input type="checkbox"/> 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: <input type="checkbox"/> Y <input type="checkbox"/> N Describe: _____				
PMH ● Been prescribed new medications by another physician? ● Been hospitalized for a non-orthopaedic condition?	<input type="checkbox"/> Y <input type="checkbox"/> N Describe: _____				
	<input type="checkbox"/> Y <input type="checkbox"/> N Describe: _____				
SH ● Changed your prior smoking status? ● What is your current job status?	<input type="checkbox"/> Y <input type="checkbox"/> N Describe: _____				
	<input type="checkbox"/> Regular job <input type="checkbox"/> Light duty <input type="checkbox"/> Not working due to this condition <input type="checkbox"/> Do not work <input type="checkbox"/> 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 _____