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Follow-Up Medical Questionnaire

Patient Name: ______________________ **DOB:** ____________ **Date:** ____________

★ WHAT BODY PART IS INVOLVED? PLEASE MARK IN TABLE BELOW.

Neck		Shoulder	Elbow	Hand	Back		Pelvis	Knee	Foot
☐ radiates to	☐ R arm ☐ L arm	☐ L ☐ R	☐ L ☐ R	☐ L ☐ R	☐ radiates to	☐ R leg ☐ L leg	☐ L ☐ R	☐ L ☐ R	☐ L ☐ R
Arm	**Wrist**	**Finger**	**Hip**	**Ankle**	**Toe**	**Leg**			
☐ L ☐ R	☐ L ☐ R	T 2 3 4 5 ☐L ☐R	☐ L ☐ R	☐ L ☐ R	B 2 3 4 5 ☐L ☐R	☐ L ☐ R			

PATIENT QUESTIONS (1–10)

1) Is there a new problem not evaluated at your last visit? ☐ Y ☐ N If so, what? ______________________

2) How long 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 no better put 0%) _____%

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

6) Quality of pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

7) Pain is now: ☐ Constant ☐ Comes and goes (intermittent) Does it wake you from sleep? ☐ Y ☐ N

8) Do you have: ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of bladder/bowel control ☐ NONE

9) What medications are you still taking for this condition? ☐ NONE
Anti-inflammatory: ______________________ Narcotic (pain killer): ______________________

10) Check treatments done at or since your last visit:

	Treatment	Did it help?
☐	Anti-inflammatories	☐ Y ☐ N
☐	Narcotics	☐ Y ☐ N
☐	Brace / Cast	☐ Y ☐ N
☐	Physical / Occupational Therapy	☐ Y ☐ N
☐	Home Exercise Program	☐ Y ☐ N
☐	Injection at last visit: short term ______ days long term ______ days	☐ Y ☐ N
☐	Surgery since last visit	☐ Y ☐ N

INTERVAL HISTORY — SINCE YOUR LAST VISIT HAVE YOU:

ROS	Developed **NEW** problems in any of these areas? Circle any problem area and describe. Allergies | Nerves | Lungs | Eyes | Skin | Stomach/Bowels | Other joints | Diabetes | Ears | Psychiatric | Weight loss/fever | Heart | Urine | Anemia ☐ I have had no new problems in these areas Describe: ______________________		
PMH	Been prescribed **NEW** medications by another physician?	☐ Y ☐ N	Describe: ____________
	Been hospitalized for a non-orthopedic condition?	☐ Y ☐ N	Describe: ____________
SH	Changed your prior smoking status?	☐ Y ☐ N	Describe: ____________
	Current job status: ☐ Regular job ☐ Light duty ☐ Not working due to condition ☐ Do not work		

★ QUESTIONS FOR THE DOCTOR — PLEASE LIST BELOW

Patient Signature	DR / NP Signature	Date