



## Follow up Medical Questionnaire

Appointment Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Provider: \_\_\_\_\_ Reason for Visit  F/U visit  F/U Injury  Post-OP

What body part is involved? (Please mark the table below)

Foot		Elbow		Wrist		Hand		Knee		Hip		Ankle		Shoulder	
L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R

### 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  No Change

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:** (Please check all that apply)

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 & Allergies \_\_\_\_\_

None  See attached list

Describe any new problem(s): \_\_\_\_\_

Been hospitalized for a non-orthopedic condition?  Y  N If yes, please describe \_\_\_\_\_

Started or stopped smoking  Y  N If yes, please describe \_\_\_\_\_

What is your current job status? Full-Time / Part-Time / Light Duty / Retired or Not Working

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_