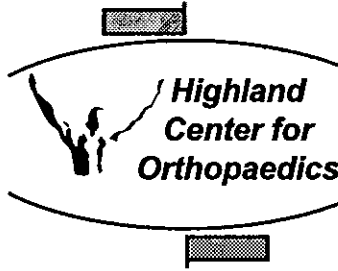


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## Follow-up Questionnaire Orthopaedic

Date: \_\_\_\_\_ Chart #: \_\_\_\_\_ Provider: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Reason for Visit:  F/U visit  
 F/u F

BP \_\_\_/\_\_\_ Pulse \_\_\_ Temp \_\_\_

What body part is Involved? Please mark in table below: \_\_\_\_\_

<input type="checkbox"/> Neck and relates to	<input type="checkbox"/> R arm <input type="checkbox"/> L arm <input type="checkbox"/> Neither	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Elbow	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Hand	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Knee	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Foot	<input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Back and relates to	<input type="checkbox"/> R arm <input type="checkbox"/> L arm <input type="checkbox"/> Neither	<input type="checkbox"/> Arm	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Wrist	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Finger T 2 3 4 5	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Hip	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Ankle	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Toes B 2 3 4 5	<input type="checkbox"/> Right <input type="checkbox"/> Left

- 1.) Is there a new problem that was not evaluated at your last visit:  Yes  No If so, 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 no better put 0%. \_\_\_\_\_ %
- ★ 5.) 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
- ★ 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 it wake you from sleep?  Yes  No
- ★ 8.) Do you have  Numbness  Tingling  Weakness  Loss of control of bowel or bladder  None
- ★ 9.) What medications are you still taking for this condition?  None  Anti-inflammatory \_\_\_\_\_  
 Narcotic (pain killer) \_\_\_\_\_
- ★ 10.) Use check box below to show what treatment was done at or since your last visit:

### TREATMENT

- Anti-Inflammatories
- Narcotics
- Brace/Cast
- Physical/Occupational Therapy
- Home Exercise Program
- Injection at last visit  Short Term  
 Long Term
- Surgery since last visit

### DID IT HELP?

- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No

### INTERVAL HISTORY Since your last visit, have you:

- ★ ROS\* Developed new problems in any of these areas?  Eyes  Heart  Bowels  Skin  Joints  
 Ears  Lungs  Urine  Diabetes  Nerves

Please Describe: \_\_\_\_\_

Developed new allergies?  Yes  No Describe: \_\_\_\_\_

- ★ PMH\* Been prescribed new medications by any other physician?  Yes  No Describe: \_\_\_\_\_

- ★ SH\* Started or stopped smoking?  Yes  No Describe: \_\_\_\_\_

What is your current job status:  Regular job  Light duty  Not working due to this condition  Do not work

Are there any questions you want the Doctor to answer for you at this visit? Please list below.

\_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ MD/PA Signature: \_\_\_\_\_ Date: \_\_\_\_\_