Follow-up Medical Questionnaire Orthopaedic Surgery

Date: _____ Chart # _____ Provider:_____

Patient Name: _____

Reason for visit ❑ F/U visit ❑ F/U Fx ❑ Post op
BP ____/____ Pulse _____ Temp_____ (E5)

What body part is involved? Please mark in table below: **(CC / Location)**

Neck ❑	and radiates to	❑ R arm ❑ L arm ❑ Neither	Shoulder	❑ R ❑ L	Elbow	❑ R ❑ L	Hand	❑ R ❑ L	Pelvis	❑ R ❑ L	Knee	❑ R ❑ L	Foot	❑ R ❑ L
Back ❑	and radiates to	❑ R leg ❑ L leg ❑ Neither	Arm	❑ R ❑ L	Wrist	❑ R ❑ L	Finger T 2 3 4 5	❑ R ❑ L	Hip	❑ R ❑ L	Ankle	❑ R ❑ L	Toe B 2 3 4 5	❑ R ❑ L

1.) Is there a new problem that was not evaluated at your last visit ❑ Y ❑ N 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 **(Context)**

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 **(Severity)**

★ 6.) What is the **quality** of the pain? ❑ Sharp ❑ Dull ❑ Stabbing ❑ Throbbing ❑ Aching ❑ Burning **(Quality)**

★ 7.) The pain is now ❑ constant ❑ comes and goes (intermittent) Does it wake you from sleep ❑ Y ❑ N **(Timing)**

★ 8.) Do you have ❑ Numbness ❑ Tingling ❑ Weakness ❑ loss of control of bowel or bladder ❑ None **(Assoc symps)**

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

Narcotic (pain killer)_____ (name)

★ 10). Use check box below to show what treatment was done at or since your last visit? **(Modify)**

Treatment	Did it help?		COMMENTS
❑ 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	❑ Y	❑ N	
long term	❑ 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? ❑ **None**
Eyes ❑Y ❑ N Heart❑ Y ❑ N Bowels ❑ Y ❑ N Skin ❑ Y ❑ N
Joints ❑ Y ❑ N Ears ❑ Y ❑ N Lungs ❑ Y ❑ N Urine ❑ Y ❑ N
Diabetes ❑ Y ❑ N Nerves ❑ Y ❑ N
Please describe:_____

• Developed **new** allergies: ❑Y ❑ N Describe _____

★**PMH** • Been prescribed **new** medications by any other physician? ❑ Y ❑ N Describe _____

• Been hospitalized for a non-orthopaedic condition? ❑ Y ❑ N Describe _____

★**SH** • Started or stopped smoking? ❑ Y ❑ N 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** _____