

# 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 <input type="checkbox"/>	and radiates to	<input type="checkbox"/> R arm <input type="checkbox"/> L arm <input type="checkbox"/> Neither	Shoulder	<input type="checkbox"/> R <input type="checkbox"/> L	Elbow	<input type="checkbox"/> R <input type="checkbox"/> L	Hand	<input type="checkbox"/> R <input type="checkbox"/> L	Pelvis	<input type="checkbox"/> R <input type="checkbox"/> L	Knee	<input type="checkbox"/> R <input type="checkbox"/> L	Foot	<input type="checkbox"/> R <input type="checkbox"/> L	Leg	<input type="checkbox"/> L <input type="checkbox"/> R
Back <input type="checkbox"/>	and radiates to	<input type="checkbox"/> R leg <input type="checkbox"/> L leg <input type="checkbox"/> Neither	Arm	<input type="checkbox"/> R <input type="checkbox"/> L	Wrist	<input type="checkbox"/> R <input type="checkbox"/> L	Finger T 2 3 4 5	<input type="checkbox"/> R <input type="checkbox"/> L	Hip	<input type="checkbox"/> R <input type="checkbox"/> L	Ankle	<input type="checkbox"/> R <input type="checkbox"/> L	Toe B 2 3 4 5	<input type="checkbox"/> R <input type="checkbox"/> 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?
<input type="checkbox"/> Anti-inflammatories	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Narcotics	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Brace/Cast	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Physical/Occupational 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
long term (____ 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

<b>ROS</b> • Developed <u>new</u> problems in any of these areas? Circle any problem area and describe <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:				
<b>PMH</b> • Been prescribed <u>new</u> medications by any other 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				
<b>SH</b> • 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				

Are there any questions you want the Doctor to answer for you at this visit? PLEASE LIST BELOW.

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

MD/PA signature \_\_\_\_\_ date \_\_\_\_\_