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%, <u>how much better</u> are you now ? If no better put 0% ____%

★ **5.)** On a scale of 0-10 (10 is the worst) how <u>severe</u> is your pain now (circle) 0 1 2 3 4 5 6 7 8 9 10 **(Severity)**

★ **6.)** What is the <u>**quality**</u> 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 <u>still taking</u> 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 <u>last visit</u>? **(Modify)**

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 <u>last</u> visit	short term (____days)	☐ Y ☐ N
	long term (____weeks)	☐ Y ☐ N
☐ Surgery since last visit		☐ Y ☐ N

INTERVAL HISTORY: <u>Since your last visit</u>, have you

ROS	• Developed <u>**new**</u> problems in any of these areas? <u>Circle</u> any problem area and describe ☐ **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:				
PMH	• Been prescribed <u>**new**</u> medications by any other physician?	☐Y ☐N Describe:				
	• Been hospitalized for a non-orthopaedic condition?	☐Y ☐N Describe				
SH	• Changed your prior smoking status?	☐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**______

★**This form creates a Complete ROS and PFSH for estab visits** (14 ROS, 2 PFSH) for E2,E3,E4 and E5 **(E5 exams require vital signs X 3)**

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