HealthCare
Orthopaedic Surgery
& Sports Medicine

FOLLOW-UP QUESTIONNAIRE

PATIENT NAME: ________________________ **MRN # :** ______________________________

APPT DATE: ___________________________ **PROVIDER:** __________________________

Part of the body involved: ◯ RT ◯ LT **Part:** ◯ Arm ◯ Leg ◯ Hand ◯ Knee ◯ Foot ◯ Other: _______________

Have your symptoms changed any since your last visit? If so, please describe:____
____

Where is your worst pain and what offsets it?____

Does the pain move anywhere else on your body? ____

What best relieves your pain? ____

How bad is your pain now? Please circle your pain level now: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain)

What is the quality of the pain: Sharp ◯ Dull ◯ Stabbing ◯ Throbbing ◯ Aching ◯ Burning ◯

Have you tried these since last visit?

	Tried?		Found helpful?	
Physical Therapy	Y ◯	N ◯	Y ◯	N ◯
Chiropractor	Y ◯	N ◯	Y ◯	N ◯
Injections	Y ◯	N ◯	Y ◯	N ◯
Medications	Y ◯	N ◯	Y ◯	N ◯
Brace/Cast	Y ◯	N ◯	Y ◯	N ◯
Crutches	Y ◯	N ◯	Y ◯	N ◯
Home Exercise Program	Y ◯	N ◯	Y ◯	N ◯
Surgery	Y ◯	N ◯	Y ◯	N ◯

What medications do you currently take? Please indicate if you are taking for the condition seen for today or if a new medication.

1.________________________________ 2.____________________________________
3.________________________________ 4.____________________________________
5.________________________________ 6.____________________________________

Do you currently smoke? Yes No **If previously, when did you stop?**___________________________

Are you currently working?
◯ Yes ◯ Yes, with restrictions/Light Duty
◯ No ◯ Unemployed and not able to work
◯ Retired, disabled, don't work outside the home

Have you been hospitalized for a non-orthopedic condition since your last visit? Yes ◯ No ◯
If Yes, Explain____

Any new problems since last visit? Please check all symptoms that apply:

	No	Yes	Explain
Eyes	◯	◯	______________
Ears	◯	◯	______________
Heart	◯	◯	______________
Lungs	◯	◯	______________
Bowels	◯	◯	______________
Joints	◯	◯	______________
Overall Health	◯	◯	______________
Nerves/Dizziness	◯	◯	______________
Diabetes or Thyroid	◯	◯	______________
Bladder/ Kidneys	◯	◯	______________
Allergies	◯	◯	______________
Psychiatric	◯	◯	______________
Skin	◯	◯	______________
Bruising/Enlarged gland	◯	◯	______________

Is there anything else we need to know today to take care of you? ____
____

Provider Signature: ____ **Date:** __________________________