Follow-Up Medical Form
(Please use black ink)

Patient Name: ___________________________ Date of Birth: __________ Age:_____ Appointment Date: __________

What body part is involved? (Please mark the table below)

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L

Is there a new problem that was not evaluated at your last visit? ◻ Y ◻ N What is it?____________________________

How long has it been since your last visit?_______ ◻ Days ◻ Weeks ◻ Months

Since your last visit, are you ◻ Better ◻ Worse ◻ Same

On a scale of 0-100%, how much better are you now? (If not better put 0) ________________%

On a scale of 0-10 (10 is the worst) how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ◻ Sharp ◻ Dull ◻ Stabbing ◻ Throbbing ◻ Aching ◻ Burning

The pain is now: ◻ Constant ◻ Comes and goes (intermittent)

Does your pain wake you from your sleep? ◻ Y ◻ N

Do you have: ◻ Swelling ◻ Bruises ◻ Numbness ◻ Weakness ◻ Tingling ◻ Locking/Catching ◻ Giving way
◻ Loss of control of bowel or bladder ◻ None

What medications are you still taking for this condition: ◻ None ◻ Anti-inflammatories_______________(name)
◻ Pain Killers (incl. narcotics)_______________(name)

Use check box below to show what treatment was done at or since you last visit:

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 Last Visit: Short Term	◻ Y ◻ N
◻ Injection at Last Visit: Long Term	◻ Y ◻ N
◻ Surgery Since Last Visit	◻ Y ◻ N

INTERVAL HISTORY: Since your last visit, have you:

ROS Developed new problems in : Eyes ◻ Y ◻ N Heart ◻ Y ◻ N Bowels ◻ Y ◻ N Skin ◻ Y ◻ N
Ears ◻ Y ◻ N Lungs ◻ Y ◻ N Urine ◻ Y ◻ N Diabetes ◻ Y ◻ N
Nerves ◻ Y ◻ N Joints ◻ Y ◻ N ◻ **NONE**

Please describe any new problems: ____

Have you developed any new ALLERGIES (food/medication/metal)? ◻ Y ◻ N Describe:____________________

PMH Been prescribed new medications by any other physicians? ◻ 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?____________________________

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Patient Signature:____________________________________ Date:________________________

Provider Signature:____________________________________