



**FOLLOW UP MEDICAL QUESTIONNAIRE** HT: \_\_\_\_\_ WT: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

What body part are you being seen for today?  RT  LT  BILAT \_\_\_\_\_

Is there a new problem that was not evaluated at your last visit  Yes  No If yes, what is it? \_\_\_\_\_

Since your last visit are you?  BETTER  SAME  WORSE

On a scale of 0-100%, **what is your level of improvement?** \_\_\_\_\_

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

Is your pain  Constant  Comes and goes (intermittent) Does your pain wake you from your sleep?  Yes  No

Do you have:  Numbness  weakness  swelling  Tingling  Locking/Catching  Giving way  Other: \_\_\_\_\_

What medications are you **currently taking** for this condition? Anti-Inflammatory \_\_\_\_\_ (name)  
Narcotic (pain killer) \_\_\_\_\_ (name)

**Check box below to show what treatment was done since your last visit:**

<u>Treatment</u>	<u>Did it Help?</u>
<input type="checkbox"/> Anti-inflammatories	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Narcotics	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Brace/Cast	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Physical/Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Home Exercise Program	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Surgery since last visit	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Injection: How long did it last? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Do you experience any of the following symptoms?**

- 1. GENERAL:** Anxiety, Depression, Wt Loss, Wt Gain, Fever, Chills, Night Sweats, Fatigue
- 2. HEENT:** Headache, difficulty swallowing, nose bleeds, ringing ears, ear ache, blurred/double vision, eye pain
- 3. CARDIOVASCULAR:** Chest pain, Palpitations, HR
- 4. RESPIRATORY:** SOB, Wheezing, Coughing, Snoring
- 5. GASTROINTESTINAL:** Nauseous, Vomiting, Diarrhea, Constipation, Bloody/Blood in stool, Heartburn

**\*ROS\*** Have you developed new allergies?  Yes  No If yes, please describe: \_\_\_\_\_

**\*PMH\*** Have you been prescribed new medications by any other provider?  Yes  No  
If yes, please describe: \_\_\_\_\_

Have you been hospitalized for a non-orthopedic condition?  Yes  No  
If yes, please describe: \_\_\_\_\_

**\*SH\*** Have you started or stopped smoking?  Yes  No If yes, please describe: \_\_\_\_\_

What is your current job status?  Regular duty  Light Duty  Not Working Due To This Condition  Do Not Work

Are there any questions you want the Provider to answer for you at this visit? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_