MVP Orthopedics and Sports Medicine

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:

Treatment	Did it Help?
☐ Anti-inflammatories	☐ Yes ☐ No
☐ Narcotics	☐ Yes ☐ No
☐ Brace/Cast	☐ Yes ☐ No
☐ Physical/Occupational Therapy	☐ Yes ☐ No
☐ Home Exercise Program	☐ Yes ☐ No
☐ Surgery since last visit	☐ Yes ☐ No
☐ Injection: How long did it last? _____	

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:** _____