MIDWEST ORTHOPÆDIC CENTER

Midwest Orthopaedic Center, SC

Follow-up Medical Questionnaire

Appt Date:_____ DOB: _____Age: _____ Provider: **Dr. Johnson, Ben Holman PA-C**

Patient Name:_____Reason for visit: ☐ f/u visit ☐ f/u FX ☐ Post-op

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

Arm ☐ R ☐ L ☐ Neither	Back- **radiates** to Leg ☐ R ☐ L ☐ Neither	Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Wrist ☐ R ☐ L	Hand ☐ R ☐ L	Hip ☐ R ☐ L	Knee ☐ R ☐ L	Ankle ☐ R ☐ L	Foot ☐ R ☐ L	Neck ☐ R ☐ L	Back ☐ R ☐ L

1) Is there a new problem that was not evaluated at your last visit? ☐ Y ☐ N If yes, 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 (*Content*)

4) On a scale of 0–100%, how much better are you now? (If no better put 0%)_____%

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

*6) What is the **quality** of the pain? ☐ sharp ☐ dull ☐ stabbing ☐ throbbing ☐ aching ☐ burning

*7) The pain is now: ☐ constant ☐ comes and goes (intermittent. Does your pain wake you from your sleep? ☐ Y ☐ N

*8) do you have: ☐ numbness ☐ tingling ☐ weakness ☐ swelling ☐ locking/catching
☐ giving way ☐ loss of control of bowel/bladder ☐ none (*Assoc Symps*)

9) What medications are you **still taking** for this condition: ☐ none ☐ anti-inflammatory _____ (name)
☐ narcotic pain killer) _____ (name)

*10) Use check box below to show what treatment was done since your **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 the 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 ☐ Y ☐ N

Please describe any new problems: _____

• Developed new allergies? ☐ Y ☐ N If yes, please describe: _____

***PMH** • Been prescribed new medications by any other physician? ☐ Y ☐ N If Yes, please describe: _____

• Been hospitalized for a non-orthopedic condition? ☐ Y ☐ N If yes, please describe: _____

***SH** • Started or stopped smoking ☐ Y ☐ N If yes, please 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 this visit? _____

_____

Patient Signature _____ Date _____

MD/PA Signature _____ Date _____