

Name: _____

DOB: _____

FOLLOW-UP MEDICAL QUESTIONNAIRE

All paperwork must be filled in with black ink.

Office Use Only
Surgery Procedure _____ Weeks _____

REASON FOR VISIT: Follow - up Surgical Consult Post-Op

CC: **WHAT ARE YOUR PROBLEMS TODAY?** Please mark below:

<input type="checkbox"/> Side of Neck	<input type="checkbox"/> R	<input type="checkbox"/> L
<input type="checkbox"/> Shoulder	<input type="checkbox"/> R	<input type="checkbox"/> L
<input type="checkbox"/> Elbow	<input type="checkbox"/> R	<input type="checkbox"/> L
<input type="checkbox"/> Wrist	<input type="checkbox"/> R	<input type="checkbox"/> L
<input type="checkbox"/> Hand	<input type="checkbox"/> R	<input type="checkbox"/> L
<input type="checkbox"/> Right Finger	<input type="checkbox"/> Thumb	<input type="checkbox"/> Index (pointer)
<input type="checkbox"/> Left Finger	<input type="checkbox"/> Thumb	<input type="checkbox"/> Index (pointer)
	<input type="checkbox"/> Middle (long)	<input type="checkbox"/> Ring
	<input type="checkbox"/> Middle (long)	<input type="checkbox"/> Small (pinky)
	<input type="checkbox"/> Ring	<input type="checkbox"/> Small (pinky)

HPI: DO YOU HAVE PROBLEMS ANYWHERE ELSE IN YOUR BODY? Yes No
Where? _____

1. Is there a new problem that was not treated at your last visit? Yes No
If so, what? _____

2. How long has it been since your last visit? _____ days _____ weeks _____ months

*3. Since your last visit, are you: better worse the same

*4. On a scale of 0 -10 (0 being no pain, 10 being the worse), how severe is your pain now? Circle: 0 1 2 3 4 5 6 7 8 9 10
Severity

*5. What is the type of pain: sharp dull stabbing throbbing aching burning no pain Quality

*6. The pain is: constant. comes and goes (intermittent) Timing

*7. Does the pain wake you from your sleep? Yes No

*8. Do you have (check all that apply) : numbness (No Feeling) tingling (Pins & Needles) weakness

Where? _____ Assoc. symp

*9 Do you have problems with loss of bladder control or urination? Yes No Is this an old problem Yes No

If yes please Explain _____

Name: _____

DOB: _____

Please answer the following questions to show what treatment was done since your **last visit**.

These questions include treatment you may have received from another doctor since your last visit.

Have you been prescribed an anti-inflammatory medicine? Yes No Type _____ Is it helping Yes No

Have you been prescribed a narcotic (pain medicine)? Yes No Type _____ Is it helping Yes No

Are you currently in a physical therapy program? Yes No Is it home based? Yes No

Is therapy helping your problem? Yes No Comments _____

Have you had an injection? Yes No Comments _____

INTERVAL HISTORY:

Since your last visit, has any of the following changed?

Review Of Systems:

• Developed **new** problems in any of these areas since your last visit? Circle and describe.

Allergies Nerves Lungs Eyes Skin Stomach/Bowels Other joints Diabetes

Ears Psychiatric Weight loss/fever Heart Urine Blood loss Anemia

Describe: _____

I have no new problems in these areas.

ROS/PMH/SH:

Since your last visit, has any of the following changed?

Past Medical History:

• Prescribed **new** medications by any other physician since your last visit? Yes No If yes, please list new medications

Been hospitalized since last visit? Yes No If yes, please explain

Surgery since last visit? Yes No When? _____ What? _____

Social History:

• Changed your prior smoking status? Yes No

• If working, what is your current job status: regular restricted not working due to the condition

Are there any questions you want the doctor to answer for you at this visit? Please list below.

Patient Signature

Date

Complete _____ Date _____ Reviewed pages 1 thru 2 by _____ M.D.