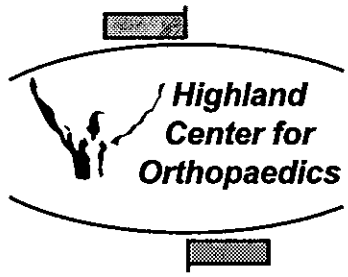
3317 U.S. Hwy. 98 South, Suite 9
Lakeland, Florida 33803
(863) 709-8777



22411 Highway 27
Lake Wales, Florida 33859
(863) 676-1571

Follow-up Questionnaire Orthopaedic

Date: _____ Chart #: _____ Provider: _____

Patient Name: _____

Reason for Visit: ❑ F/U visit ❑ F/u F

BP___/___Pulse____Temp___

What body part is Involved? Please mark in table below: _____

❑ Neck and relates to	❑ R arm ❑ L arm ❑ Neither	❑ Shoulder	❑ Right ❑ Left	❑ Elbow	❑ Right ❑ Left	❑ Hand	❑ Right ❑ Left	❑ Pelvis	❑ Right ❑ Left	❑ Knee	❑ Right ❑ Left	❑ Foot	❑ Right ❑ Left
❑ Back and relates to	❑ R arm ❑ L arm ❑ Neither	❑ Arm	❑ Right ❑ Left	❑ Wrist	❑ Right ❑ Left	❑ Finger T 2 3 4 5	❑ Right ❑ Left	❑ Hip	❑ Right ❑ Left	❑ Ankle	❑ Right ❑ Left	❑ Toes B 2 3 4 5	❑ Right ❑ Left

1.) Is there a new problem that was not evaluated at your last visit: ❑ Yes ❑ No If so, 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

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 now? (circle) 0 1 2 3 4 5 6 7 8 9 10

★ 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 it wake you from sleep? ❑ Yes ❑ No

★ 8.) Do you have ❑ Numbness ❑ Tingling ❑ Weakness ❑ Loss of control of bowel or bladder ❑ None

★ 9.) What medications are you still taking for this condition? ❑ None ❑ Anti-inflammatory _____
❑ Narcotic (pain killer) _____

★ 10.) Use check box below to show what treatment was done at or 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
❑ Injection at last visit ❑ Short Term	❑ Yes ❑ No
❑ Long Term	❑ Yes ❑ No
❑ Surgery since last visit	❑ Yes ❑ No

INTERVAL HISTORY Since your last visit, have you:

★ **ROS*** Developed new problems in any of these areas? ❑ Eyes ❑ Heart ❑ Bowels ❑ Skin ❑ Joints ❑ Ears ❑ Lungs ❑ Urine ❑ Diabetes ❑ Nerves

Please Describe: _____

Developed new allergies? ❑ Yes ❑ No Describe: _____

★ **PMH*** Been prescribed new medications by any other physician? ❑ Yes ❑ No Describe: _____

★ **SH*** Started or stopped smoking? ❑ Yes ❑ No 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? Please list below.

_____

_____

Patient Signature: _____ MD/PA Signature: _____ Date: _____

3317 U.S. Hwy. 98 South, Suite 9
Lakeland, Florida 33803
(863) 709-8777

22411 Highway 27
Lake Wales, Florida 33859
(863) 676-1571

www.highlandortho.com

Patient Questionnaire

(PLEASE PRINT)

Patient Name:_____ Date of Birth: _____

Patient Signature: _____ Date: _____

Please complete for your chart. Please answer by putting a checkmark in the appropriate box.

RACE

- ❑ American Indian / Alaska Native
- ❑ Asian
- ❑ Black/African American
- ❑ Declined
- ❑ Nat Hawaiian / Pacific Islander
- ❑ Other Race
- ❑ White

RELIGION

- ❑ Buddhist
- ❑ Catholic
- ❑ Hindu
- ❑ Islam
- ❑ Jewish
- ❑ Protestant
- ❑ Other
- ❑ N/A

ETHNICITY

- ❑ Declined
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino

PREFERRED COMMUNICATIONS

- ❑ Declined
- ❑ Email
- ❑ Fax
- ❑ Mail
- ❑ Patient Portal
- ❑ Phone
- ❑ Text