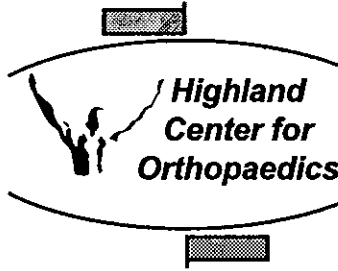


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Lakeland, Florida 33803
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Follow-up Questionnaire Orthopaedic

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: _____

<input type="checkbox"/> Neck and relates to	<input type="checkbox"/> R arm <input type="checkbox"/> L arm <input type="checkbox"/> Neither	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Elbow	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Hand	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Knee	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Foot	<input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Back and relates to	<input type="checkbox"/> R arm <input type="checkbox"/> L arm <input type="checkbox"/> Neither	<input type="checkbox"/> Arm	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Wrist	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Finger T 2 3 4 5	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Hip	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Ankle	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Toes B 2 3 4 5	<input type="checkbox"/> Right <input type="checkbox"/> 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

- Anti-Inflammatories
- Narcotics
- Brace/Cast
- Physical/Occupational Therapy
- Home Exercise Program
- Injection at last visit Short Term
 Long Term
- Surgery since last visit

DID IT HELP?

- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- 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: _____

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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