Orthopaedic Follow-up Survey

Date: _____ Chart#: _____ Provider:_____

Patient Name: _____ BP__/__ Pulse _____ Temp. _____

Follow-up Problem(s): (+) New Problem:

1.) How long has it been since your last visit? _____ ❒ Days ❒ Weeks ❒ Months

2.) Since your last visit, are you: ❒ Better ❒ Worse ❒ Same

3.) On a scale of 0-100%, how much better are you now? _____%

4.) How severe is your pain now? ❒ Mild ❒ Moderate ❒ Severe ❒ Extremely Severe

5.) What has been done for you since your *last visi*t? (Use check box below.)

Treatment Has this helped? Comments

❒ Anti-inflammatories ❒ Y ❒ N _____ (Name)

❒ Narcotics ❒ Y ❒ N _____ (Name)

❒ Brace/Cast ❒ Y ❒ N

❒ Physical Therapy ❒ Y ❒ N

❒ Injection ❒ Y ❒ N

INTERVAL HISTORY: Since your last visit, have you:

6.) Felt any **new** ❒ Numbness ❒ Tingling ❒ Swelling ❒ Weakness [❒ No]

7.) Developed **new** ❒ Allergies ❒ nausea, vomiting, blood in stool [❒ No]

8.) Taken **new** medications? ❒ Yes ❒ No Name: _____

9.) Started or stopped smoking? ❒ Yes ❒ No

10.) **Are there any questions you want the doctor to answer for you at this visit?**

PLEASE LIST BELOW.

_____

_____

_____

M.D._____