MD WEST | ONE

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# Orthopedic Follow-up History Form

**Patient Name:** ________________________________________ **Appt Date:** ____________ **with Dr.**______________________

**What is the reason for this visit?** ☑ Follow-up visit ☑ Post-operative visit ☑ Fracture follow-up

**Is there a new problem that was not evaluated at your last visit?** ☐ Y ☐ N If yes, what is it? ____________________________

**Since your last visit, are you:** ☑ Better ☐ Worse ☐ Same

**On a scale of 0-100%, how much better are you now? (if no better put 0%)** ________%

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

**What is the quality of the pain?** ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

**The pain is now:** ☐ Constant ☐ Comes and goes (intermittent)

**Does your pain wake you from your sleep?** ☐ Y ☐ N

**Do you have:** ☐ Numbness ☐ Tingling ☐ Weakness ☐ Swelling ☐ Locking/Catching ☐ Giving Way

☐ Loss of control of bowel or bladder ☐ None

**What medications are you still taking for this condition?** ☐ None ☐ Anti-inflammatory (name) ☐ Narcotic (pain killer)

**What treatment was at or since your last visit and did it help?**

- ☐ **Anti-inflammatories** ☐ Y ☐ N
- ☐ **Physical therapy** ☐ Y ☐ N
- ☐ **Home exercise program** ☐ Y ☐ N
- ☐ **Injection** ☐ Y ☐ N (if yes, did it help long or short term? ☐ long ☐ short)

**Have you developed any 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

**Please describe any new problem:** ______________________________________________________________

**Developed new allergies? ☐ Y ☐ N If yes, please describe:**__________________________________________

**Past Medical History:**

**Have you been prescribed any new medications by other physician?** ☐ Y ☐ N If yes, what medication? ___________

**Social History:**

**Since your last visit have you started or stopped smoking?** ☐ Y ☐ N ☐ Never smoked ☐ Previously quit

**Are there any questions you want the doctor or PA to answer for you at this visit?** ________________________________

______________________________________________________________________________

______________________________________________________________ ________________________

Patient Signature Date

1.__________________________________ 2.__________________________ ________________________

Doctor/PA signature Date