Follow-Up Medical Questionnaire

Please complete all information below.

ORTHOWASHINGTON

Patient Information

Patient Name: _____ Date of Birth: _____

Doctor's Name: _____ Appointment Date: _____

What body part(s) is this visit regarding?

SHOULDER: ☐ Left ☐ Right **ELBOW:** ☐ Left ☐ Right **WRIST:** ☐ Left ☐ Right

HAND: ☐ Left ☐ Right **HIP:** ☐ Left ☐ Right **KNEE:** ☐ Left ☐ Right

ANKLE: ☐ Left ☐ Right **FOOT:** ☐ Left ☐ Right OTHER: _____

What is the reason for today's visit?

1. ☐ Pain ☐ Numbness ☐ Swelling ☐ Weakness ☐ Other: _____
2. How long has it been since your last visit? Days: _____ Weeks: _____ Months: _____ Years: _____
3. Since you last visit, how are you feeling? ☐ Better ☐ Worse ☐ Same ☐ Too early to tell
4. On a scale of 0 to 100%, **how much better** are you than the last visit? (0% = no better): % _____
5. On a scale of 0 to 10 (10 is worst), what is the severity of your pain? (circle one): 0 1 2 3 4 5 6 7 8 9 10
6. What is the **quality** of your pain? ☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing
7. The pain is now: ☐ Constant ☐ Intermittent (comes and goes)
8. Does the pain wake you when sleeping? ☐ Yes ☐ No
9. Do you have: ☐ Bruising ☐ Giving Way ☐ Locking ☐ Catching ☐ Popping ☐ Numbness
   ☐ Swelling ☐ Tingling ☐ Weakness ☐ Other: _____

What treatment(s) have you received since your last visit?

☐ Activity Modification (e.g. no lifting)

☐ Brace ☐ Cast ☐ Crutches ☐ Sling ☐ Walker ☐ Scooter ☐ Other: _____

☐ Chiropractic Care ☐ Massage Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Hand Therapy

☐ Icing ☐ Heat ☐ Elevating ☐ Home Exercise Program

☐ Injection at Last Visit – Type: _____

☐ Prescriptions (please list): _____

☐ Over-the-counter Medications (please list): _____

☐ Surgery since last visit – Type: _____ Date: _____

☐ Other: _____

Patient Signature: _____ Date: _____

MD/PA-C Signature: _____ Date: _____

FOR OFFICE USE ONLY – Do not write below this line.

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