Follow-Up Questionnaire – Orthopedic

Acct #:_____ Date:_____

CORE Provider:_____

For office use only

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Date of Injury: _____ Date of Surgery: _____

PRESENT MEDICAL INFORMATION

What body part is involved? (please check all that apply below)

Ankle: ☐R ☐L Arm: ☐R ☐L Back: ☐ Elbow: ☐R ☐L

Finger: _____ ☐R ☐L Foot: ☐R ☐L Hand: ☐R ☐L Hip: ☐R ☐L

Knee: ☐R ☐L Leg: ☐R ☐L Neck: ☐ Pelvis: ☐

Shoulder: ☐R ☐L Toe: _____ ☐R ☐L Wrist: ☐R ☐L Other: _____

On a scale of 0-100%, how much better are you now? (if not better, put 0%) _____

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

What is the quality of your pain: ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning

What medications are you still taking for this problem? ☐None ☐Narcotic: _____

☐Anti-inflammatory: _____ ☐Other: _____

If you had surgery for this condition, on a scale of 0 – 10 (10 = most pleased), how pleased are you with the outcome of your surgery?

Are there any questions you want the doctor to answer during this visit? _____

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name: _____

Patient Signature: _____ Date: _____

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Reviewed By: _____ Date: _____

Last Revision Date: 8.30.2016