FOLLOW-UP QUESTIONAIRE

Patients Name: ______________________ Today's Date ______________

Height _______ Weight _______

What body part is involved? (circle which side)

Shoulder R / L Elbow R / L Arm R / L Wrist R / L Hand R / L

Fingers R / L Hip R / L Knee R / L Ankle R / L Neck Back

How long has it been since your last visit? ______________

Since your last visit, are you:

- Feeling Better
- Feeling Worse
- Feeling the same

On a scale of 0 – 100%, how much better are you now? ________%

On a scale of 0 through 10 (10 being worst), **how severe is your pain?**

0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain?

- Sharp
- Dull
- Stabbing
- Throbbing
- Aching
- Burning
- Other ______________

Is the pain:

- Constant
- Intermittent
- Wakes me from sleep
- Other ______________

Do You have:

- Swelling
- Numbness
- Tingling
- Weakness
- Bruising
- Other ______________

What medications are you still taking for this condition? • None

- Anti-inflammatory ______________
- Narcotic ______________

Have you developed new problems in any of these areas?

- Allergies
- Nerves
- Lungs
- Ears
- Eyes
- Skin
- Stomach/Bowels
- Diabetes
- Urine
- Other Joints
- Weight Loss
- Fever
- Heart
- Anemia
- Psychiatric
- Other ______________

Describe any <u>new</u> problems:

- I have no new problems in these areas.

Have you been prescribed any new medications by another physician? • Yes • No

Have you been hospitalized for a non-orthopedic condition? • Yes • No

Describe:

Do you smoke? • Yes PPD ________ • No

What is your current job status?

- Regular job
- Light Duty
- Do Not Work
- Retired
- Not working/on disability due to condition

Have you had any Physical Therapy? • Yes • No

Where:

Dates: ____/____/____ to ____/____/____

Has your pharmacy info changed? • Yes • No

New Pharmacy:

Location:

Are you currently under the care of a pain management physician? Phone #

The information on this form is accurate and to the best of my knowledge.

________________________ ____________

Patients Signature Date

________________________ ____________

Physician Signature
Date

• Yes • No Date Care Started ____________

Physician's Name ____________________________

List Medications prescribed by this physician ____________

____

____

**Please note: We do not generally prescribe pain medication for long term use. All pain medications are closely monitored and prescribed on an "as needed" basis.

PAIN DIAGRAM: Please indicate areas of <u>pain, numbness, tingling, and/or burning</u> on the following diagram (2 body part limit):

Pain= P Numbness= N Tingling= T Burning=B