**Appointment Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_**Age:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Care Physician**:

1. **Reason for visit:** 🞏 follow up Visit 🞏 f/u Fracture care 🞏 Post-op: Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_ 🞏 Other:
2. What body part and side are involved?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Shoulder   * R  L | Elbow   * R  L | Wrist   * R  L | Hand   * R  L | Hip   * R  L | Knee   * R  L | Ankle   * R  L | Foot   * R  L | Neck   * R  L | Back   * R  L |

1. Is there a new problem that was not evaluated at your last visit? 🞏 Y 🞏 N If yes, what is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Since your last visit, are you: 🞏 better 🞏 worse 🞏 same
3. On a scale of 0–100%, how much better are you now? (0%=not better) \_\_\_\_\_\_\_\_\_%
4. On a scale of 0–10 (10 is the worst) how severe is your pain at its worst? (circle, choose range) 0 1 2 3 4 5 6 7 8 9 10
5. What is the quality of the pain? 🞏 sharp 🞏dull 🞏 stabbing 🞏 throbbing 🞏 aching 🞏 burning
6. The pain is now: 🞏 constant 🞏 comes and goes (intermittent). Does your pain wake you from your sleep? 🞏 Y 🞏 N
7. Do you have (additional symptoms):❑ swelling ❑ bruises ❑ numbness ❑ tingling ❑ weakness ❑locking/catching ❑ giving way ❑ fevers/chills ❑ abrasions/lacerations/wounds ❑ gait difficulty
8. What medications are you **still taking** for this condition: 🞏None 🞏 Anti-Inflammatory \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name)

🞏 Narcotic pain killer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name)

1. Use check box below to show what treatment was done since your last visit:

**Treatment** **Did it help?**

🞏 Anti-inflammatories 🞏 Y 🞏 N

🞏 Narcotics 🞏 Y 🞏 N

🞏 Brace/Cast 🞏 Y 🞏 N

🞏 Physical/Occupational Therapy 🞏 Y 🞏 N

🞏 Home Exercise Program 🞏 Y 🞏 N

🞏 Cane/Crutches/Walker 🞏 Y 🞏 N

🞏 Injection at last visit 🞏 Y 🞏 N

🞏 Surgery since last visit 🞏 Y 🞏 N

**Interval history**: Since the last visit, have you:

\*ROS •Developed 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 None 🞏 Y 🞏 N General (fevers) 🞏 Y 🞏 N

•Please describe any new problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

•Developed new allergies? 🞏 Y 🞏 N If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*PMH •Been prescribed new medications by any other physician? 🞏 Y 🞏 N If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

•Been hospitalized for a non-orthopedic condition? 🞏 Y 🞏 N If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*SH •Started or stopped smoking 🞏 Y 🞏 N If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

•What is your current job status? 🞏 regular job 🞏 light duty 🞏 not working due to this condition 🞏 do not work

\*Medications:

\*Drug Allergies:

**Are there any questions you want the doctor to answer for you this visit?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

MD Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_