

ACCOUNT# _____ DATE: _____

CORE PHYSICIAN: _____

FOR OFFICE USE ONLY

Patient Name _____ DOB _____ Age _____ E-mail _____

Height _____ Weight _____

Reason for Visit: Follow-up Visit Follow-up Fracture Post-Op

Date of Injury: ____/____/____ Date of Surgery (if applicable): ____/____/____

PRESENT MEDICAL INFORMATION

What body part is involved? (Please check below)

Ankle: <input type="checkbox"/> R <input type="checkbox"/> L	Arm: <input type="checkbox"/> R <input type="checkbox"/> L	Back: <input type="checkbox"/>	Elbow: <input type="checkbox"/> R <input type="checkbox"/> L
Finger _____ <input type="checkbox"/> R <input type="checkbox"/> L	Foot: <input type="checkbox"/> R <input type="checkbox"/> L	Hand: <input type="checkbox"/> R <input type="checkbox"/> L	Hip: <input type="checkbox"/> R <input type="checkbox"/> L
Knee: <input type="checkbox"/> R <input type="checkbox"/> L	Leg: <input type="checkbox"/> R <input type="checkbox"/> L	Neck: <input type="checkbox"/>	Pelvis: <input type="checkbox"/>
Shoulder: <input type="checkbox"/> R <input type="checkbox"/> L	Toe _____ <input type="checkbox"/> R <input type="checkbox"/> L	Wrist: <input type="checkbox"/> R <input type="checkbox"/> L	Other: _____

Is there a new problem that was not evaluated at your last visit? Yes No If yes, please describe: _____

How long has it been since your last visit? _____ Days _____ Weeks _____ Months _____ Years

Since your last visit, are you: Better Worse Same

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

On a scale of 0-10 (10=worst) how severe is your pain? (circle) 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

Does your pain wake you from sleep? Yes No

Do you have the following

<input type="checkbox"/> Bruising	<input type="checkbox"/> Joints giving way	<input type="checkbox"/> Hands feeling clumsy	<input type="checkbox"/> Locking/Catching
<input type="checkbox"/> Numbness	<input type="checkbox"/> Poor Balance	<input type="checkbox"/> Swelling	<input type="checkbox"/> Tingling
<input type="checkbox"/> Weakness	<input type="checkbox"/> Loss of control of bladder		

What medications are you still taking for this problem? None Narcotic _____
 Anti-inflammatory _____ Other _____

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

Anti-inflammatories <input type="checkbox"/> Y <input type="checkbox"/> N	Brace/Cast <input type="checkbox"/> Y <input type="checkbox"/> N	Cane/ Crutches <input type="checkbox"/> Y <input type="checkbox"/> N	Injection <input type="checkbox"/> Y <input type="checkbox"/> N
Physical Therapy <input type="checkbox"/> Y <input type="checkbox"/> N	Pain Medicine <input type="checkbox"/> Y <input type="checkbox"/> N	Walker <input type="checkbox"/> Y <input type="checkbox"/> N	

If you have had surgery for this condition, on a scale of 0-10 how pleased are you with the outcome of your surgery? (10=most pleased) 0 1 2 3 4 5 6 7 8 9 10

Since your last visit have you developed new problems with the following:

Bowels: <input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes: <input type="checkbox"/> Y <input type="checkbox"/> N	Ears: <input type="checkbox"/> Y <input type="checkbox"/> N	Eyes: <input type="checkbox"/> Y <input type="checkbox"/> N
Heart: <input type="checkbox"/> Y <input type="checkbox"/> N	Lungs: <input type="checkbox"/> Y <input type="checkbox"/> N	Skin: <input type="checkbox"/> Y <input type="checkbox"/> N	Urine: <input type="checkbox"/> Y <input type="checkbox"/> N

Developed new allergies? Y N If yes, please describe: _____

Been prescribed new medication? Y N If yes, please describe: _____

Been hospitalized for a non-orthopedic condition? Y N If yes, please describe: _____

Started/Stopped smoking? Y N If yes, please describe: _____

Please describe any new problems: _____

Current employment status: Disabled Full-time Retired Student Light-duty (how long? _____)
 Unemployed due to this problem

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

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

Patient/Representative Name (print) _____ Signature _____ Date ____/____/____

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Reviewed by _____ Date ____/____/____