

# New Braunfels Orthopaedics & Sports Medicine

## RETURN/FOLLOW-UP MEDICAL QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

/ (for staff use only)

What body part is involved? *Please mark below:*

<input type="checkbox"/> Neck <i>Radiates to:</i> <input type="checkbox"/> R Arm <input type="checkbox"/> L Arm	<b>Shoulder</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <b>Elbow</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Arm</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <b>Wrist</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Hand</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <b>Finger</b> <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Back <i>Radiates to:</i> <input type="checkbox"/> R Leg <input type="checkbox"/> L Leg	<b>Pelvis</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <b>Hip</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Knee</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <b>Ankle</b> <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>Foot</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <b>Toe</b> <input type="checkbox"/> Right <input type="checkbox"/> Left

- 1 Is there a new problem that was not evaluated your last visit?  Y  N
- 2 If yes, what is it? \_\_\_\_\_
- 3 How long has it been since your last visit? \_\_\_\_\_  Days  Weeks  Months
- 4 Since your last visit are you:  Better  Worse  Same
- 5 On a scale of 0-100%, How much BETTER are you? (If no better, put 0) \_\_\_\_\_ %
- 6 On a scale of 0-10 (10 is needing an ambulance), how severe is your pain? (circle)  
 0 1 2 3 4 5 6 7 8 9 10
- 7 Describe the pain:  Sharp  Burning  Stabbing  Throbbing  Aching  Dull
- 8 The pain is:  Constant  Intermittent(Comes & Goes)
- 9 Does the pain wake you up?  Y  N
- 10 Do you have:  Loss of bladder/bowel  Bruising  Numbness  Weakness  Tingling  Swelling
- 11 What medications are you STILL taking for this condition?  Anti-inflammatory: \_\_\_\_\_  
 Pain-killer: \_\_\_\_\_

12 Use check box below to show what treatment was done at or since your LAST visit?

Treatment	Did It Help?
<input type="checkbox"/> Anti-inflammatories	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Narcotics (pain killers)	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Brace/cast	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Physical/Occupational Therapy	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Home Exercise Program	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Injection at LAST visit	<input type="checkbox"/> Y <input type="checkbox"/> N
Short-term (_____)days	
Long-term (_____)days	
<input type="checkbox"/> Surgery since last visit	<input type="checkbox"/> Y <input type="checkbox"/> N

Since your last visit, have you developed new problems in any of these areas:

- |                                      |                                |                                   |                                  |                                       |                                      |
|--------------------------------------|--------------------------------|-----------------------------------|----------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> Nerve | <input type="checkbox"/> Lungs    | <input type="checkbox"/> Eyes    | <input type="checkbox"/> Skin         | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Ears  | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach | <input type="checkbox"/> Other joints |                                      |
| <input type="checkbox"/> Fever       | <input type="checkbox"/> Heart | <input type="checkbox"/> Urinary  | <input type="checkbox"/> Anemia  | <input type="checkbox"/> Bowels       | <input type="checkbox"/> NONE        |

Describe problems: \_\_\_\_\_

Have you been prescribed new medications by any other physician?  Y  N

Describe: \_\_\_\_\_

Have you been hospitalized for a non-orthopaedic condition?  Y  N

Describe: \_\_\_\_\_

Have you changed your prior smoking status?  Y  N

Work status:  Regular  Light Duty (How long?) \_\_\_\_\_  Disabled  Retired  Student  
 Not working due to this problem What was the last date you worked your job? \_\_\_\_\_

Are there any questions you want the Doctor to answer for you at this visit? PLEASE LIST. \_\_\_\_\_