

Follow-up Medical Questionnaire

Date: _____ Chart # _____ Provider: _____
 Patient Name: _____

BP ____ / ____ Pulse ____ Temp ____

What body part is involved? *Please mark in table:*

<input type="checkbox"/> Neck Pain and radiates to:	<input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> None	Shoulder <input type="checkbox"/> Right <input type="checkbox"/> Left	Hand <input type="checkbox"/> Right <input type="checkbox"/> Left	Pelvis <input type="checkbox"/> Right <input type="checkbox"/> Left	Knee <input type="checkbox"/> Right <input type="checkbox"/> Left	Foot <input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Back Pain and radiates to:	<input type="checkbox"/> Left leg <input type="checkbox"/> Right leg <input type="checkbox"/> None	Arm <input type="checkbox"/> Right <input type="checkbox"/> Left	Finger T,2,3,4,5 <input type="checkbox"/> Right <input type="checkbox"/> Left	Hip <input type="checkbox"/> Right <input type="checkbox"/> Left	Ankle <input type="checkbox"/> Right <input type="checkbox"/> Left	Toe 2,3,4,5 <input type="checkbox"/> Right <input type="checkbox"/> Left

1. Is there a new problem that was not evaluated at your last visit: Y N If so, what is it? _____
2. How long has it been since your last visit? _____ Days Weeks Months
3. Since your last visit, are you: Better Worse Same
4. On a scale of 0-100%, how much better are you now? (If no better put 0%) _____%
5. On a scale of 0-10 (10 is the worst), how severe is your pain now? 0 1 2 3 4 5 6 7 8 9 10
6. What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning
7. The pain is now: Constant Comes and goes (intermittent). Does it wake you from sleep? Y N
8. Do you have Numbness Tingling Weakness Loss of bowel or bladder None
9. What medications are you still taking for this condition? None Anti-inflammatory _____ (name)
 Narcotic (pain killer) _____ (name)
10. Use check box below to show what treatment was done at your last visit?

Treatment	Did it help?
<input type="checkbox"/> Anti-inflammatories	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Narcotics	<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 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 short term (____days)	<input type="checkbox"/> Y <input type="checkbox"/> N
long term (____days)	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Surgery since last visit	<input type="checkbox"/> Y <input type="checkbox"/> N

Interval History: <i>Since your last visit, have you</i>					
Developed new problems in any of these areas? <i>Circle any problem area and describe</i>		Allergies	Nerves	Lungs	Eyes
		Stomach/Bowels	Other Joints	Diabetes	Skin
<input type="checkbox"/> I have no new problems in these area		Weight loss/fever	Heart	Urine	Psychiatric
Describe any problems:					
Been prescribed new medications by any other physicians?		<input type="checkbox"/> Y <input type="checkbox"/> N Describe:			
Been hospitalized		<input type="checkbox"/> Y <input type="checkbox"/> N Describe:			
Changed your prior smoking status?		<input type="checkbox"/> Y <input type="checkbox"/> N Describe:			
What is your current job status?		<input type="checkbox"/> Regular job <input type="checkbox"/> Light Duty <input type="checkbox"/> Not working due to this condition <input type="checkbox"/> Do not work <input type="checkbox"/> Retired			

Are there any other questions you want the doctor to answer for you at this visit? Please list below:

 Patient Signature: _____ MD/PA Signature _____ Date _____