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INCORPORATED

Diplomat American Academy of Orthopedic Surgery

FOLLOW UP HEALTH QUESTIONNAIRE

Patient Name:_____ Date of Birth:_____ Age:_____

Height: _____ Weight:_____

What is the reason for today's visit/chief complaint?:

Do you need a work note or forms completed? ☐Yes ☐ No Form/note type: _____

Do you need a prescription or refill? ☐Yes ☐ No If so, what medication:_____

Pain level today (1-10):_____

What are your current symptoms:

New Medications Since LAST VIST(including OTC/vitamins/herbals/supplements) ☐ **No Changes**

Medication	Dosage & Frequency	Purpose & Administered route i.e. oral/IV/topical	Physician

Do you have any drug allergies? ☐Yes ☐ No If so, list:_____

Treatment Since LAST VISIT ☐ **No Changes**

	YES	**NO**	**Number of Visits**	**Facility**
Physical Therapy				
Chiropractic				
Acupuncture				
Injections				

-Type(i.e epidural, facet, ablation):

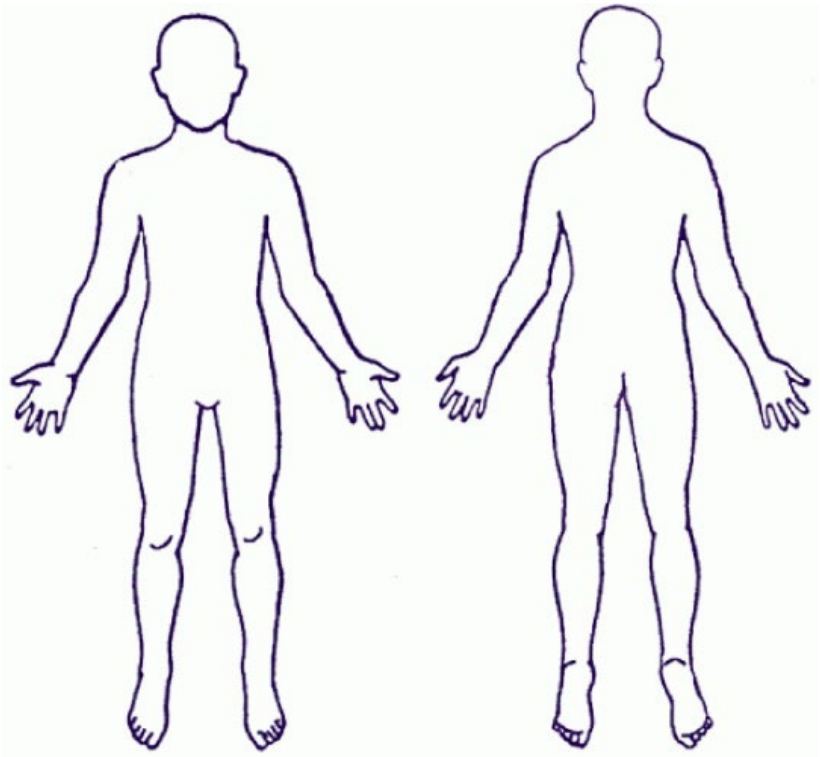
Medications: ***Please List***				
Brace				
Home Exercise Program				
Surgery:_____				

Diagnostics Since LAST VISIT ☐ **No Changes**

	YES	**NO**	**Body Part**	**Facility**
MRI / CT				
X-Ray				
EMG/ Nerve Conduction Study				
Other:				

Patient Name: _____ Date of Birth:_____

Below "X" the areas you feel pain



Please describe your pain:

Have you been diagnosed with a new illness or had any changes in your health since we last saw you?
☐Yes ☐ No If yes, what is it:

Have you had a fall in the last 12 months? ☐Yes ☐ No More than 2 times? ☐Yes ☐ No

Office use:
Pulse:_____ BP:_____ BMI:_____
General Appearance: ☐ Well nourished ☐ Not well nourished ☐ Stand Normally ☐ Doesn't stand normally
Oriented x 3: ☐ Awake ☐ Responsive ☐ Oriented of person/place/time
Mood and Affect: ☐ Normal ☐ Not Normal

_____ _____

Patient Signature (Date) **Provider Signature (Date)**