Newton Wellesley Orthopedic Associates
Follow-up Medical Questionnaire

Patient Name:_____

What body part is involved? (Please mark the table below)

Shoulder L R	Elbow L R	Wrist L R	Hand L R	Hip L R	Knee L R	Ankle L R	Foot L R	Neck	Back

Since your last visit, how are you? □ Better □ Worse □ Same

On a scale of 0 – 100%, how much better/worse are you now? (If no better/worse put 0%)_____%

On a scale of 0 – 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of your pain? □ Sharp □ Dull □ Stabbing □ Throbbing □ Aching □ Burning □ None

The pain is now: □ Constant □ Comes and goes (intermittent) □ Absent

Do you have: □ Numbness □ Tingling □ Weakness □ Swelling □ Locking / Catching □ Giving way

□ Loss of control of bowel or bladder □ Stiffness □ **None of the above**

What medications are you still taking for this condition? □ Anti-Inflammatory(Name)_____

□ Narcotic (name)_____ □ **None**

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

□ Anti-inflammatories	Did it help?	□ Y □ N
□ Narcotics		□ Y □ N
□ Brace/Cast		□ Y □ N
□ Physical/ Occupational Therapy		□ Y □ N
□ Home Exercise Program		□ Y □N
□ Injection at last visit--short-term		□ Y □ N
□ Injection at last visit--long-term		□ Y □ N
□ Surgery since last visit		□ Y □ N

Have you developed any new orthopedic problems since your last visit?_____

_____

Interval Medical-Family-Social History

Since your last visit, have you developed new problems with your: □ Skin □ Eyes/Ears/Nose/Throat □ Heart □ Lungs

□ Bowels □Urine □ Diabetes □ Nerves □ Joints □ **None**

Please describe any new medical problem:_____

Have you developed new allergies? □ Y □ N. If yes, describe:_____

Have new medications been prescribed? □ Y □ N If Yes, describe: _____

Have you been hospitalized for a non-orthopedic condition? □ Y □ N. If Yes, describe:_____

Have there been any changes in your Family medical history?_____

Do you use tobacco? □ Y □ N If yes, packs per day_____ **Alcohol use?** □ Y □ N How often?_____

Occupation/Current work status:_____

PLEASE SIGN: The information on this form is accurate to the best of my knowledge.

Patient Signature_____Date_____MD/PA Signature_____