

Newton Wellesley Orthopedic Associates
Follow-up Medical Questionnaire for Hand Patients

Patient Name: _____

Reason for Visit

Shoulder L R	Elbow L R	Wrist L R	Hand L R	Thumb L R	Index Finger L R	Long Finger L R	Ring Finger L R	Small Finger L R
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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 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**:

- | | | |
|--|--------------|---|
| <input type="checkbox"/> Anti-inflammatories | Did it help? | <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/ 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--short-term | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Injection at last visit--long-term | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Surgery since last visit | | <input type="checkbox"/> Y <input type="checkbox"/> 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 _____ MD/PA Signature _____ Date _____