CALIFORNIA ORTHOPEDICS & SPINE

Follow-up Medical Form

_____ _____

Appointment Date With Dr.

_____

Patient Name

This form is used to gather information so that my doctor can maximize the time used to examine me and answer my questions about my condition and treatment options. I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

_____ _____

Patient Signature (Date) MD/PA Signature (Date)

Today you are scheduled for your

Do not write in this box/For official use only

How long has it been since your last visit?_____ ☐ Days ☐ Weeks ☐ Months

Since your last visit, are you: ☐ Better ☐ Worse ☐ Same

On a scale of 0-100%, how much have you improved since your last visit? (If no better 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 the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is **now**: ☐ Constant ☐ Comes and goes (intermittent) Does your pain wake you from your sleep? ☐ Y ☐ N

Do you have: ☐ Swelling ☐ Bruises ☐ Numbness ☐ Tingling ☐ Weakness ☐ Locking/Catching

☐ Buckling/Giving Way

What medications are you still taking for this condition? ☐ None ☐ Anti-Inflammatory_____(Name)

☐ Narcotic (pain killer)_____(Name)

What makes it better?_____

What makes it worse?_____

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

Treatment	Did it help?	
☐ Anti-inflammatories	☐ Y	☐ N
☐ Narcotics	☐ Y	☐ N
☐ Brace	☐ Y	☐ N
☐ Physical/Occupational Therapy	☐ Y	☐ N
☐ Home Exercise Program	☐ Y	☐ N
☐ Injection at last visit	☐ Y	☐ N

Please complete reverse side of this form

Review of Systems

Developed new problems in: Eyes ☐ Y ☐ N Heart ☐ Y ☐ N Bowels ☐ Y ☐ N

Ears ☐ Y ☐ N Skin ☐ Y ☐ N Lungs ☐ Y ☐ N

Urine ☐ Y ☐ N Diabetes ☐ Y ☐ N Nerves ☐ Y ☐ N

Joints ☐ Y ☐ N

Please describe any <u>new</u> problem: _____

_____

Have you developed <u>new</u> allergies? ☐ Y ☐ N If yes, please describe: _____

_____

Have you been prescribed <u>new</u> medications by any other physicians? ☐ Y ☐ N If yes, please describe: _____

_____

Have you been hospitalized for a non-orthopedic condition? ☐ Y ☐ N If yes, please describe: _____

_____

Have you started or stopped smoking? ☐ Y ☐ N If yes, please describe: _____

_____