Name:
DOB:
Chart:
Age:
Date:

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Reason for visit: _______f/u visit _______f/u fracture _______post spine injection

What body part is involved? (Please circle) LEFT RIGHT

shoulder	arm	elbow	wrist	hand	finger	neck
pelvis	hip	knee	ankle	foot	toe	back

Is there a new problem that was not evaluated at your last visit? (CIRCLE) YES NO If yes, what is it? ____________

How long has it been since your last visit? ____ days ____ weeks ____ months

Since your last visit, are you: (circle) BETTER WORSE SAME

On a scale of 0-100%, **how much better** are you now? _________ (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 your pain? (Circle) SHARP DULL STABBING THROBBING ACHING BURNING

Is the pain now: (circle) CONSTANT COMES AND GOES

Does your pain wake you up from sleep? (circle) YES NO

Do you have: (circle any that applies) NUMBNESS TINGLING WEAKNESS SWELLING LOCKING/CATCHING GIVING WAY LOSS OF CONTROL OF BOWEL OR BLADDER NONE

Are you still taking medication for this condition: (circle) YES NO If yes, please specify type:____________________

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

Treatment	**Did it help?**
☐ anti-inflammatory	☐ Yes ☐ No
☐ narcotics	☐ Yes ☐ No
☐ brace/cast	☐ Yes ☐ No
☐ physical/occupational therapy	☐ Yes ☐ No
☐ home exercise program	☐ Yes ☐ No
☐ injection at last visit: short term	☐ Yes ☐ No
☐ injection at last visit: long term	☐ Yes ☐ No
☐ surgery since last visit	☐ Yes ☐ No

INTERVAL HISTORY: since last visit have you developed new problem in: (circle if yes)

EYES HEART BOWELS SKIN EARS LUNGS URINE DIABETES NERVES JOINTS NONE

Please describe new problem: ____________

Developed new allergies? (Circle) YES NO If yes, please describe: ____________

Been prescribed new medication by any other physician:: (circle) YES NO If yes, please describe: ____________

Been hospitalized for a non orthopedic condition?? (Circle) YES NO If yes, please describe: ____________

What is your current job status? (Circle) FULL DUTY LIGHT DUTY NOT WORKING DUE TO CONDITION DO NOT WORK

Are there any questions you want the doctor to answer for you at this visit? ____________

Patient Signature: ____________ MD Signature: ____________ Date: ____________