

FOLLOW-UP MEDICAL QUESTIONNAIRE – DR. LOREN

Patient Name: _____ Date: _____

Reason for Visit: Routine follow-up – Problem: _____
 Test results XRay MRI CT Bone Scan Nerve Test (EMG/NCV) _____
 Change in condition – Describe: _____
 Post-op – Surgery: _____ Date: _____
 Pre-op – Surgery: _____ Date: _____

What is the **primary body part** involved?

Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Wrist/Hand <input type="checkbox"/> R <input type="checkbox"/> L
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How long ago did was your previous visit? _____ Days _____ Weeks _____ Months _____ Years

Is there a new problem that was not evaluated at the last visit? Yes No

If Yes, explain: _____

Since your last appointment, the problem is now Better Worse Unchanged.

On a scale of 0% -- 100%. how much **better** are you? _____%

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

Is the pain Constant or Intermittent (comes and goes)? Does the pain disrupt sleep? Yes No

Additional symptoms: Swelling Bruising Numbness/Tingling Weakness Locking/Catching Giving Way

Symptoms worsened by Standing Walking Bending Squatting Kneeling Stairs Sitting Twisting

Lifting/Reaching Exercise/Sports (specify, _____) Daily Activities _____

What medications are you currently taking for this problem? _____

What treatment was done at or since your last visit and was it helpful?

TREATMENT

- Anti-inflammatory medication _____
- Narcotic pain medication _____
- Injection/shot: short-term (first hours to day)
- Injection/shot: long-term (first days to weeks)
- Cast/Brace
- Physical/Occupational Therapy
- Home Exercise Program
- Surgery

ANY RELIEF?

- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No Unknown

Since your last visit, have you

- Been diagnosed with any additional medical conditions? Yes No _____
- Been hospitalized for any other condition? Yes No _____
- Had any medications prescribed, changed, or discontinued? Yes No _____
- Developed any new allergies? Yes No _____
- Developed new symptoms in: Eyes Ears, Nose, Throat Heart Lungs Skin
 Intestines Urinary Tract Bones/Joints Nerves Blood

Describe any **new** problem: _____

What is you current work status? regular job modified/light duty not working due to this condition not employed/retired

Additional comments: _____

Signature _____