ELLIOT ORTHOPAEDIC SURGICAL SPECIALISTS
FOLLOW-UP HEALTH QUESTIONNAIRE

Today's Date (MM/DD/YYYY):____/_____/_____
Name:_____**Age:**_____**Birthdate:**_____

1) **Regarding the area you are being seen for today, have there been any functional changes since your last visit** (ie changes in motion, strength, ability to utilize the affected region in daily activities or sports)? Please describe below.

_____
_____
_____

2) **Are you experiencing pain at the affected area?** Yes / No

If Yes: How would you describe the usual severity of your pain (circle rating of 1-10 for severity of symptoms with 10 being the worst)?

1 2 3 4 5 6 7 8 9 10

very mild ----------→ moderate----------→worst possible

Is your pain: intermittent / constant

Is your pain: sharp / dull / burning / pressure / other _____

Since your last visit, has your pain:

improved / worsened / stayed the same

Which activities aggravate your pain (circle all applicable)?

climbing stairs / walking / running / sleeping / lifting / throwing a ball / dressing / working / reaching for a seat-belt / getting up from a chair / shaking hands / other_____

List any activities or medications that make the pain better:

_____

GENERAL MEDICAL INFORMATION

Please list any new medical problems/diagnoses since your last orthopaedic visit

_____
_____
_____
_____ _____

Please list any surgeries since your last orthopaedic visit (please list below and provide date, surgeon, hospital/city if known):

_____
_____
_____
_____
_____
_____

Today's Date (MM/DD/YYYY):____/_____/_____
Name:_____**Age:**_____**Birthdate:**_____

Please list any new medical conditions in your family since your last orthopaedic visit (list family member and problem)

_____
_____
_____

Social History:

Since your last visit, has there been any change in your exercise / sport activity? Yes / No

If yes, please comment:_____
_____

Since your last visit, has there been any change in your use (or non-use) of cigarettes, cigars, chew, or alcohol? Yes / No

If yes, please comment:_____

Review of Systems:

Do you experience any of the following symptoms?

Yes / No	Fever	Yes / No	Chills
Yes / No	Abnormal weight loss/gain	Yes / No	Headaches
Yes / No	Blurred vision	Yes / No	Double vision
Yes / No	Partial/Complete vision loss	Yes / No	Ringing in the ears
Yes / No	Hearing aid usage	Yes / No	Nose bleeds
Yes / No	Seasonal allergies	Yes / No	Sinus infections
Yes / No	Difficulty swallowing	Yes / No	Hoarseness/voice change
Yes / No	Neck lumps/swelling	Yes / No	Bleeding gums
Yes / No	Pain of mouth/gums or teeth	Yes / No	Frequent toothache
Yes / No	Chest pain	Yes / No	Swelling of extremities
Yes / No	Palpitations	Yes / No	Excessive sweating
Yes / No	Excessively cold	Yes / No	Fainting
Yes / No	Shortness of breath	Yes / No	Pain with breathing
Yes / No	Night leg cramps	Yes / No	Abdominal pain
Yes / No	Nausea	Yes / No	Vomiting
Yes / No	Diarrhea	Yes / No	Constipation
Yes / No	Hemorrhoids	Yes / No	Skin lesions / rashes
Yes / No	Excessive thirst	Yes / No	Excessive urination
Yes / No	Urinary incontinence	Yes / No	Urinary retention
Yes / No	Memory loss	Yes / No	Tremors
Yes / No	Vertigo / Imbalance	Yes / No	Clumsiness/lack of coordination
Yes / No	Speech difficulty	Yes / No	Excessive fatigue
Yes / No	Panic attacks	Yes / No	Depression
Yes / No	Insomnia	Yes / No	Easy bruising / bleeding
Yes / No	Food allergies	Yes / No	Change in bowel/bladder habits
Yes / No	Varicose veins	Yes / No	Urinary tract infections

Thank you for completing this form.

FOR OFFICE USE ONLY – Reviewed by:_____