Orthopaedic Follow-up Survey

Date: ________, Chart # ________ Patient Name: ________________________________

Provider: __________________ Date of Surgery (if postop): __________ Follow-up problem(s) ________

1.) How long has it been since your last visit? _________ ☐ Days ☐ Weeks ☐ Months

PERTINENT INFORMATION REQUIRED:

Changes to Medical History:

__________________________________________________________

Please list any NEW Medications: (E4)

__________________________________________________________

Allergies (New):

__________________________________________________________

★ 2.) Since your last visit are you: ☐ Better ☐ Worse ☐ Same

a. On a scale of 0-100%, how much better are you now? ________%

★ b. How severe is your pain now? ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe

★ c. What has been done for you since your last visit? (Use check box below)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Has this helped?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Surgery</td>
<td>☐ Y ☐ N</td>
</tr>
<tr>
<td>☐ Anti-inflammatories</td>
<td>☐ Y ☐ N</td>
</tr>
<tr>
<td>☐ Narcotics</td>
<td>☐ Y ☐ N</td>
</tr>
<tr>
<td>☐ Brace/ Cast</td>
<td>☐ Y ☐ N</td>
</tr>
<tr>
<td>☐ Physical Therapy</td>
<td>☐ Y ☐ N</td>
</tr>
<tr>
<td>☐ Injection</td>
<td>☐ Y ☐ N</td>
</tr>
</tbody>
</table>

INTERVAL HISTORY: Since your last visit, have you:

(E3) 3.) Felt any new ☐ Numbness ☐ Tingling ☐ Swelling ☐ Weakness [ ☐ No ] (ROS) (MS)

(E4) 4.) Developed new ☐ Nausea, vomiting, blood in stool [ ☐ No ] (ROS) (2-9)

(E5) 6.) Started or stopped smoking? ☐ Y ☐ N (SHx) (+ 14 ROS + VS)

Patient Signature: ________________________________ M.D. ________________________________

(E3) = Minimum dictation for Estab. Level 3 (E3) + (E4) = Minimum dictation for Estab. Level 4 (E3) + (E4) + (E5) = Minimum dictation for Estab. Level 5