Orthopedic Follow-up Survey

Date: ________________ Patient Name: ____ MRN #: ____________

Provider: ________________ Follow-up Problem(s): ____

If you are here for a **post-op visit**, what was the date of your surgery? _________________________

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

PERTINENT INFORMATION REQUIRED

Please list any Changes to Medical History:

____

____

Please list any NEW Medications: (E4)

____

____

Please list any NEW Allergies:

____

____

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 boxes below)

Treatment Type	Has this helped?	
☐ Surgery	☐ Yes	☐ No
☐ Anti-inflammatories	☐ Yes	☐ No
☐ Narcotics	☐ Yes	☐ No
☐ Brace or Cast	☐ Yes	☐ No
☐ Physical Therapy	☐ Yes	☐ No
☐ Injection	☐ Yes	☐ No

INTERVAL HISTORY

Since your last visit, have you:

(E3)	3. Felt any **NEW**	☐ Numbness	☐ Tingling	☐ Swelling	☐ Weakness	☐ None
(E4)	4. Developed **NEW**	☐ Nausea	☐ Vomiting	☐ Blood in Stool	☐ None	
(E5)	5. Started or Stopped Smoking?	☐ Yes	☐ No			

Patient Signature: ___________________________ **Physician Signature:** _________________________

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