Tulane Institute of Sports Medicine
Follow-up Medical Questionnaire

Appointment Date:_____ **Chart #** _____ **Provider**_____

Patient Name: _____ **Reason for visit:** ❑ f/u visit ❑ f/u FX ❑ Post op

What body part is involved? (please mark the table below)

❑ R arm ❑ L arm ❑ Neither	Shoulder ❑ R ❑ L	Elbow ❑ R ❑ L	Hand ❑ R ❑ L	Pelvis ❑ R ❑ L	Knee ❑ R ❑ L	Foot ❑ R ❑ L
❑ Back and radiates to: ❑ R arm ❑ L arm ❑ Neither	Arm ❑ R ❑ L	Wrist ❑ R ❑ L	Finger T 2 3 4 5 ❑ R ❑ L	Hip ❑ R ❑ L	Ankle ❑ R ❑ L	Toe B 2 3 4 5 ❑ R ❑ L

1) Is there a new problem that was not evaluated at your last visit? ❑ Y ❑ N If yes, what is it? _____
2) How long has it been since your last visit? _____ ❑ days ❑ weeks ❑ months
3) Since your last visit, are you: ❑ better ❑ worse ❑ same
4) On a scale of 0 – 100%, how much better are you now? (if no better put 0%) _____%
5) 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
6) What is the **quality** of your pain? ❑ sharp ❑ dull ❑ stabbing ❑ stabbing ❑ throbbing ❑ aching ❑ burning
7) The pain is now: ❑ constant ❑ comes and goes (intermittent). Does your pain wake you from sleep? ❑ Yes ❑ No
8) Do you have: ❑ numbness ❑ tingling ❑ weakness ❑ swelling ❑ locking/catching ❑ giving way
❑ loss of control of bowel or bladder ❑ none
9) What medications are you still taking for this condition: ❑ none ❑ Anti-inflammatory _____ (name)
❑ Narcotic (pain killer) _____ (name)
10) Use check box below to show what treatment was done at or since your last visit:

Treatment	Did it help?
❑ Anti-inflammatories	❑ Y ❑ N
❑ Narcotics	❑ Y ❑ N
❑ Brace/Cast	❑ Y ❑ N
❑ Physical / Occupational Therapy	❑ Y ❑ N
❑ Home Exercise Program	❑ Y ❑ N
❑ Injection at last visit: short term	❑ Y ❑ N
❑ Injection at last visit: long term	❑ Y ❑ N
❑ Surgery since last vitis	❑ Y ❑ N

INTERVAL HISTORY: Since last visit have you:

Developed new problem in:
Eyes ❑ Y ❑ N Heart ❑ Y ❑ N Bowels ❑ Y ❑ N Skin ❑ Y ❑ N
Ears ❑ Y ❑ N Lungs ❑ Y ❑ N Urine ❑ Y ❑ N Diabetes ❑ Y ❑ N
Nerves ❑ Y ❑ N Joints ❑ Y ❑ N ❑ None

Please describe new problem:_____
Developed new allergies? ❑ Y ❑ N If yes, please describe:_____
Been prescribed new medication by any other physician? ❑ Y ❑ N If yes, please describe: _____
Been hospitalized for a non-orthopedic condition? ❑ Y ❑ N If yes, please desicribe:_____
What is your current job status? ❑ regular job ❑ light duty ❑ not working due to this condition ❑ do not work
Are there any questions you want the doctor to answer for you at this visit? _____
_____

Patient Signature:_____ MD Signature_____ Date_____