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)

Treatment	**Has this helped?**
☐ Surgery	☐ Y ☐ N
☐ Anti-inflammatories	☐ Y ☐ N
☐ Narcotics	☐ Y ☐ N
☐ Brace/ Cast	☐ Y ☐ N
☐ Physical Therapy	☐ Y ☐ N
☐ Injection	☐ Y ☐ N

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)

(E5) **6.)** Started or stopped smoking? ☐ Y ☐ N (2-9) (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