

PATIENT FOLLOW-UP VISIT QUESTIONNAIRE - PLEASE COMPLETE THE FOLLOWING INFORMATION:

NAME: _____ AGE: _____ DATE OF BIRTH: ____/____/____

Are you here today for a new problem? Yes No (If Yes, skip to next section)

Have you had surgery with us? Yes No (If No, go to next section)

If you have had surgery please state the side and type of operation:

Right / Left / Bilateral _____

How long has been since your surgery? _____ weeks / months / years

Current *Chief* Concern, if any:

Any secondary or unrelated concerns?

Any changes since last visit? Yes No

If Yes, Please State:

CURRENT WORK STATUS: Full time Part time Homemaker Retired Disabled Not Working

CURRENT LEVEL OF DISCOMFORT:
 (Mark line with x)
 0 1 2 3 4 5 6 7 8 9 10
 No Pain Worst Pain

THE DISCOMFORT IS: Getting Better Getting Worse Unchanged

HAVE THERE BEEN ANY CHANGES IN YOUR HEALTH OR HOSPITALIZATIONS SINCE YOUR LAST VISIT? Yes No

If Yes, Please State: _____

HAVE THERE BEEN ANY CHANGES IN YOUR MEDICATIONS OR ALLERGIES SINCE YOUR LAST VISIT? Yes No

If Yes, Please State: _____

HAVE YOU HAD ANY OTHER SURGERIES SINCE YOUR LAST VISIT? Yes No

If Yes, Please State: _____

HAVE THERE BEEN ANY CHANGES FOR YOU OR YOUR FAMILY IN ANY OF THE FOLLOWING SYSTEMS SINCE YOUR LAST VISIT?

CARDIOVASCULAR	<input type="checkbox"/> Yes <input type="checkbox"/> No	PSYCHIATRIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
GASTROINTESTINAL	<input type="checkbox"/> Yes <input type="checkbox"/> No	RENAL	<input type="checkbox"/> Yes <input type="checkbox"/> No
HEMATOLOGIC	<input type="checkbox"/> Yes <input type="checkbox"/> No	RESPIRATORY	<input type="checkbox"/> Yes <input type="checkbox"/> No
MUSCULOSKELETAL	<input type="checkbox"/> Yes <input type="checkbox"/> No	REPRODUCTIVE	<input type="checkbox"/> Yes <input type="checkbox"/> No
NEUROLOGIC	<input type="checkbox"/> Yes <input type="checkbox"/> No	UROLOGIC	<input type="checkbox"/> Yes <input type="checkbox"/> No

If Yes, Please State: _____

PATIENT'S SIGNATURE: _____ Date ____/____/____

(OFFICE USE ONLY): I attest that the above information was personally reviewed and updated

PROVIDER SIGNATURE _____ Date ____/____/____