

Orthopaedic and Spine Specialists

Follow-up Medical Questionnaire - Dr. Ulmer

Patient Name (print): _____ Todays Date: _____

Age: _____ M F Dominant Hand R L Height: _____ Weight _____

1. What is the reason for this visit? Follow-up Fracture Post-op Other _____

2. What body part is involved? Please check below.

Neck <input type="checkbox"/>	and <input type="checkbox"/> R arm	Shoulder <input type="checkbox"/> R	Arm <input type="checkbox"/> R	Elbow <input type="checkbox"/> R	Wrist <input type="checkbox"/> R	Hand <input type="checkbox"/> R	Finger <input type="checkbox"/> R
	Radiates to <input type="checkbox"/> L arm	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L
Back <input type="checkbox"/>	and <input type="checkbox"/> R leg	Pelvis <input type="checkbox"/> R	Hip <input type="checkbox"/> R	Knee <input type="checkbox"/> R	Ankle <input type="checkbox"/> R	Foot <input type="checkbox"/> R	Toe <input type="checkbox"/> R
	Radiates to <input type="checkbox"/> L leg	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L	<input type="checkbox"/> L

3. Is there a new problem since your last visit? N Y Please describe: _____

4. How long has it been since your last visit? _____ Days Weeks Months

5. Since your last visit, are you: Better Worse Same

6. On a scale of 0-100%, how much better are you now? If no better put 0% _____%

7. On a scale of 0-10 (10 is the worst) how severe is your pain now? 0 1 2 3 4 5 6 7 8 9 10

8. What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning _____

9. The pain is now? Constant Comes and goes (intermittent) Does pain wake you from sleep? Y N

10. Do you have? Swelling Bruising Numbness Tingling Weakness None

11. What medications are you still taking for this condition? none
Anti-inflammatory _____
Pain killers _____

12. Use the check box below to show what treatment was done at your last visit?

Treatment	Did it help?
<input type="checkbox"/> Anti-inflammatories	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Narcotics (pain killers)	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Brace/cast	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Home exercise program	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Injection at last visit	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Surgery since last visit	<input type="checkbox"/> Y <input type="checkbox"/> N

13. What is your current job status? Regular Light/Restricted duty not working due to this condition
 Do not work/retired Disabled

14. Do you have any questions you would like answered today?