Anderson Orthopaedic Clinic
Medical History Form—Follow Up Patient

Patient Name: _____ Date of Birth: _____

Appointment Date:_____

1) **Reason for Visit:** ☐ Follow Up ☐ Post Operative visit ☐ Other: _____

2) **Which body part is involved?** (Be specific – including side (right or left) and/or a particular finger) _____

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 (0 is no pain, 10 is worst pain imaginable) how severe is your pain?** (circle) 0 1 2 3 4 5 6 7 8 9 10

6) **The pain is now:** ☐ Constant ☐ Intermittent (comes and goes) ☐ Only with certain movements: _____

7) **Does anything make your symptoms better or worse?** Explain: _____

8) **Does your pain wake you from your sleep?** ☐ Y ☐ N

9) **Do you have:** ☐ Swelling ☐ Numbness/Tingling ☐ Weakness ☐ Locking/Catching ☐ None ☐ Other: _____

10) **What treatment have you had since your last visit?**

Treatment	Did it Help?
☐ Medication (name: _____)	☐ Y ☐ N
☐ Brace/Cast	☐ Y ☐ N
☐ Home Exercise Program	☐ Y ☐ N
☐ Physical or Occupational Therapy	☐ Y ☐ N
☐ Cortisone Injection at last visit	☐ Y ☐ N
☐ Surgery since last visit	☐ Y ☐ N

CURRENT MEDICATIONS

What Medications are you taking now?

_____
_____
_____
_____
_____
_____

Do you have any medication ALLERGIES? ☐ Y ☐ N

*If yes, please list:_____

In the last month, have you had any of the following? (Check only those for which your answer is "yes.")

☐ **CHECK HERE IF "NO" TO ALL**

☐ Stomach ulcers ☐ Nausea ☐ Vomiting ☐ Blood in Stool ☐ Chills ☐ Fever ☐ Unintentional Weight Loss ☐ Chest Pain
☐ Palpitations ☐ Skin Lesions ☐ Rashes ☐ Headaches ☐ Numbness/Tingling

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SOCIAL HISTORY: Do you use tobacco? ☐ Y ☐ N If yes, packs per day? _____ If no, were you ever an active smoker? ☐ Y ☐ N

What is your current job status? ☐ Regular ☐ Light Duty ☐ Not working due to this condition ☐ Do not work or retired

Are there any questions you want the Doctor to answer for you at this visit? _____

_____

Preferred Pharmacy Name:_____ **Phone:**_____ **Address:**_____
Update Email Address:_____ Update Preferred Phone #:_____

PLEASE SIGN: The information on this form is accurate to the best of my knowledge.

Signature: _____ Date: _____

For Staff Only: HT:_____ WT:_____ BP/P/R: _____ Reviewed By: _____ Date:_____