MedStar Orthopaedic Institute

Appointment:_________________

Medical Evaluation Questionnaire
Follow-up Form

Patient Name (print)__________________________________Date of Birth_________________ ☐ F ☐M Age_____

What body part is involved? _________________________ ☐R ☐L ☐Bilateral

Time since your last visit?_________ ☐days ☐weeks ☐months How is your condition? ☐better ☐same ☐worse

On a scale of 0 – 100 %, how much better are you now than last visit? ___________________%

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

How would you describe your pain? ☐Dull ☐Aching ☐Sharp ☐Throbbing ☐Burning ☐Stabbing

Consistency of pain is? ☐None ☐Constant ☐Occasional Does your pain wake you from sleep? ☐Yes ☐No

Do you have ☐Numbness ☐Tingling ☐Weakness ☐Loss of control of bowel movement/bladder ☐None Apply

List all medications you are currently taking (including over the counter): ☐ No changes in meds since last visit

Start Date	Medication(s)	Dosage	Route	Frequency	Prescriber

Since your last visit, have any of the following helped you? (Check only the treatments that apply)

Treatment	Did it help? (Yes or No)
☐ Anti-inflammatory	☐ Yes ☐ No
☐ Narcotics	☐ Yes ☐ No
☐ Brace/Cast	☐ Yes ☐ No
☐ Physical / Occupational Therapy	☐ Yes ☐ No
☐ Home Exercise Program	☐ Yes ☐ No
☐ Injection at last visit? If yes, then for how long?________________________	☐ Yes ☐ No

Since your last visit, have you had any new problems: ☐ None apply

☐ Allergies ☐ Eyes ☐ Nerves ☐ Lungs ☐ Skin ☐ Stomach/Bowels ☐ Other Joints ☐ Diabetes ☐ Ears

☐ Psychiatric ☐ Weight Loss ☐ Fever ☐ Heart ☐ Urine ☐ Anemia ☐ Other___________________________

Describe any that apply: ____

Been hospitalized? ☐ Yes ☐ No Reason? ____

Changed smoking status? ☐ Yes ☐ No Describe:____

Work Status? ☐ Regular ☐ Light Duty ☐ Not working due to condition ☐ Do not work

_______________________________________ Date: _________________ ______________________________

Patient or Responsible Party Signature **MD Signature**