MIDLANDS
orthopaedics
& NEUROSURGERY

Follow Up Questionnaire

Patient's Name;____ DOB:___________________

***Development of New Allergy since last visit? No Yes, ____

Current Pain Scale: (circle one number)

	MILD			MODERATE			SEVERE				
NO PAIN	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN

Please circle ONE answer for each question that applies to you:

- **Are you working?** Not at all | modified duty | regular duty
- **Athletics?** No participation | non-contact | full participation
- **How are you feeling:** Improving | Same | Worse
- **Previous PT**: none | did not help | helped a little | helped temporarily | helped significantly
- **Previous Injections:** none | did not help | helped a little | helped temporarily | helped significantly
- **Medications:** Helping a little | helping a lot | not helping at all | upsetting stomach | Not taking any medications for orthopedic problems
- **Change in symptoms**: No | Yes

Please describe any changes in your health since your last visit:

Please indicate if any of your medications have changed since your last visit: