

## Taos Orthopaedic Institute Orthopaedic Follow-Up Survey

(For Office Use Only)

Date: \_\_\_\_\_ Medical Record # \_\_\_\_\_

Patient Name: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Saturation \_\_\_\_\_ SANE Rating \_\_\_\_\_

Follow-up problem(s) \_\_\_\_\_ (+) New problem \_\_\_\_\_ (cc/location)

Did you bring x-rays/MRI?  Yes  No

1. How long has it been since your last visit? \_\_\_\_\_  Days  Weeks  Months

2. Since your last visit, are you:  Better  Worse  Same (Context)

3. On a scale of 0-100%, how much better are you now? \_\_\_\_\_ %

4. How severe is your pain now?  Mild  Moderate  Severe  Extremely Severe (Severity)

5. What has been done for you since your last visit? (Use check box below)

Treatment	Has this helped:	COMMENTS
Anti-inflammatories	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ (Name)
Narcotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ (Name)
Brace/Cast	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Injection	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe: _____

**INTERVAL HISTORY:** Since your last visit, have you:

6. Felt any **new**  Numbness  Tingling  Swelling  Weakness ( No) (ROS)

7. Developed **new**  Allergies  Nausea, vomiting, blood in stool ( No) (ROS)

8. Taken new medications?  Yes  No Name: \_\_\_\_\_ (PMHx)

9. Started or stopped smoking?  Yes  No (SHx)

10. Are there any questions you want the doctor to answer for you at this visit? PLEASE LIST BELOW.

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Provider Name \_\_\_\_\_ Provider Signature \_\_\_\_\_