Date of Surgery: ________________
Global Period: ________________
Date of Injection: ________________
Injection type: ________________
No Surgery/all forms: ______________

Taos Orthopaedic Institute Follow-Up Survey

Date: _________________**Medical Record #**____________________

Patient Name: ____

Height______**Weight**______**Pulse**______**Saturation**______**SANE**___________

Follow-up problem(s)___________________(+)**New problem**________________**(cc/location)**

Did you bring x-ray/MRI? ☐ Yes ☐ No

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1. How long has it been since your last visit?____ ☐ Days ☐ Weeks ☐ Months
2. Since your last visit, are you: ☐ Better ☐ Worse ☐ Same
3. On a scale of 0-100%, how much better are you now? __________%
4. How severe is your pain now? ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe
5. What has been done for you since your last visit? **(Use check box below)**

______Treatment		Has this helped:	COMMENTS
Anti-inflammatories	☐ Yes ☐ No	☐ Yes ☐ No	_____________________(Name)
Narcotics	☐ Yes ☐ No	☐ Yes ☐ No	_____________________(Name)
Brace/Cast	☐ Yes ☐ No	☐ Yes ☐ No	
Physical Therapy	☐ Yes ☐ No	☐ Yes ☐ No	
Injection	☐ Yes ☐ No	☐ Yes ☐ No	
Other		☐ Yes ☐ No	Describe:______________________

INTERVAL HISTORY: Since your last visit, have you:

6. Felt any **new** ☐ Numbness ☐ Tingling ☐ Swelling ☐ Weakness ☐ None (ROS)
7. Developed **new** ☐ Allergies ☐ Nausea, vomiting, blood in stool ☐ None (ROS)
8. Taken new medications? ☐ Yes ☐ No Name:____________________ (PMHx)
9. Do you smoke? ☐ Yes ☐ No
10. Started or stopped smoking? ☐ Yes ☐ No (SHx)
11. Are there any questions you want the doctor to answer for you at this visit? PLEASE LIST BELOW.

____
____
____
____

TOI Physician Name:____________________ **Physician Signature:**______________________