OrthoArizona
Canyon Orthopaedic Surgeons

PATIENT FOLLOW UP FORM

name _____ date _____

NEW information since completing your last Canyon Orthopaedics History or Follow up Form on _____

Have you had treatment for this problem? ☐ rest ☐ test (MRI,etc) ☐ medication ☐ therapy ☐ splint ☐ injection ☐ surgery

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Where is the pain located? _____

For each, circle what **BEST** applies:

- The pain is: BETTER WORSE SAME
- The pain is: RARE INTERMITTENT CONSTANT
- On a 0 to 10 severity scale (worst = 10) the pain is a: 0 1 2 3 4 5 6 7 8 9 10

Circle **ALL** that apply:

- associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NIGHT PAIN OTHER _____

What makes it worse? _____ better? _____

Other information about your problem: _____

☐ **NO NEW** symptoms, history, or medications **(STOP HERE.)** Otherwise, please complete below.

NEW Symptoms: ☐ **NONE.** Circle all that apply:

☐ yes ☐ no	Constitutional	unexpected weight loss, weight gain, fever, chills, night sweats, fatigue
☐ yes ☐ no	Eyes	blurred / double vision, eye pain, redness, watering
☐ yes ☐ no	ENT	headache, difficulty swallowing, nose bleeds, ringing in ears, earaches
☐ yes ☐ no	Cardiovascular	chest pain, palpitations, fainting, murmurs
☐ yes ☐ no	Respiratory	shortness of breath, wheezing, coughing, painful breathing, snoring
☐ yes ☐ no	Gastrointestinal	heartburn, nausea, constipation, incontinence, diarrhea, bloody / black stools
☐ yes ☐ no	Genitourinary	urinary frequency, urgency, difficulty, pain, bleeding, incontinence
☐ yes ☐ no	Musculoskeletal	other joint pains, swelling, instability, stiffness, redness, heat, muscle pain
☐ yes ☐ no	Skin	skin changes, poor healing, rash, itching, redness
☐ yes ☐ no	Neurological	numbness / tingling, unsteady gait, dizziness, tremors, seizures
☐ yes ☐ no	Psychological	nervousness, anxiety, depression, hallucinations
☐ yes ☐ no	Hematologic	easy bleeding, bruising
☐ yes ☐ no	Endocrine	excessive thirst or urination, heat / cold intolerance
☐ yes ☐ no	Allergic	reaction to foods or environment

NEW Medical, Surgical, Family or Social History: ☐ **NONE.** If yes, explain: _____

NEW Medications: ☐ **NONE**

Medication (include over the counter medicines and nutritional supplements)	**Reason Used**	**Dose**
1.		
2.		
3.		
4.		

NEW Medication Side Effects (heartburn, nausea, rash, other): ☐ **NONE**

☐ anti-inflammatory ☐ pain medication ☐ antibiotic ☐ other _____

physician review _____ date _____