HOSPITAL FOR SPECIAL SURGERY

Kenton H. Fibel, MD.

Follow-Up/New Problem Visit

Today's Date_____

Name: _____ Age: _____ DOB: _____

○ Right Handed ○ Left Handed Sex: ○ Male ○ Female

Home # _____ Work # _____

Occupation: _____ Referring Doctor: _____

For a new injury please fill out the below:

Chief Complaint: _____

Date of injury or onset of symptoms: _____

Describe the location of your pain: _____

Describe the injury or problem: _____

_____

_____

Have there been any changes in your health since your last visit such as new medical problems or changes to your medications? _____

Current Medications: _____

Allergies: _____

_____

_____

Rate Your Pain on a Scale of 0-10 *(0 = No Pain 10 = Extreme Pain):*

Right now: _____ At best: _____ At worst: _____

Quality of Pain (sharp, dull, burning, etc): _____

Is the pain constant or intermittent? _____

What makes it better? _____

What makes it worse? _____

Have you had any of the following tests or treatments for this problem? (please check)

Tests	*Date(s) of your tests*	*Treatments* (Please name & describe if they helped)	
☐ X-RAY	_____	☐ MEDICATIONS	_____
☐ MRI	_____	☐ INJECTIONS	_____
☐ CT SCAN	_____	☐ SURGERY	_____
☐ BONE SCAN	_____	☐ PHYSICAL THERAPY	_____
☐ OTHER TESTS	_____	☐ OTHER TREATMENTS	_____

Prior to having your above complaint, please describe your typical physical activities and hours/mileage for each per week (sports, training, cardio, weights, yoga, work commute, etc):

1. _____
2. _____
3. _____

Current Symptoms or Problems

Please check Yes or No for any of the following that apply to you:

Yes	No		Yes	No	
☐	☐	Recent weight change	☐	☐	Ulcers
☐	☐	Change in bowel habits (also blood in stools)	☐	☐	Hepatitis or gallbladder disease
☐	☐	Fatigue/weakness	☐	☐	Frequent headaches
☐	☐	Blood disorder or blood transfusion	☐	☐	Fainting spells
☐	☐	Fever, chills	☐	☐	Seizures
☐	☐	Easy bleeding	☐	☐	Problems with coordination
☐	☐	Easy bruising	☐	☐	Depression
☐	☐	Skin rash/disease	☐	☐	Thyroid problems
☐	☐	Change in urinary habits (including pain, blood in urine, trouble stopping/starting your urine)	☐	☐	Change in appetite or thirst
			☐	☐	Shortness of breath or wheezing
☐	☐	Kidney disease or kidney stones	☐	☐	Frequent cough
☐	☐	Vision problems/eye disease	☐	☐	Chest pain
☐	☐	Eating disorder	☐	☐	Heart murmur
☐	☐	Nose/throat problem	☐	☐	Irregular heart beat
☐	☐	Hearing problems/ear disease	☐	☐	Heart disease
☐	☐	Stomach pain or heartburn	☐	☐	Swollen legs or feet

Signed by Patient: _____ ***Date:*** _____

Office only: *Reviewed by:* _____ *Date:* _____