HOSPITAL FOR SPECIAL SURGERY

FOLLOW-UP VISIT

NEW PROBLEM

Brett Toresdahl, MD

Name: _____ Age: _____ Today's Date: _____

Current Problem: _____

Which side is affected? □ Right □ Left □ Both

When did the injury occur or symptoms begin? _____

How did the injury occur or symptoms begin? _____

_____

_____

What is the status of your symptoms, e.g., stable, improving, worsening? _____

When are your symptoms most severe, e.g., morning, evening, at night? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Rate your pain on a scale of 0-10 (0 = no pain, 10 = extreme pain):

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

What is the quality of your pain, e.g., sharp, dull, burning? _____

Is the pain constant or intermittent? _____

What other symptoms do you have, e.g., stiffness, weakness, popping, swelling, numbness, tingling? _____

_____

Have you seen another physician for your injury/symptoms? □ Yes □ No

If yes, please describe: _____

Have you experienced anything similar to this in the past? □ Yes □ No

If yes, please describe: _____

Have you had any of the following tests or treatments for this problem?

Tests	*Date(s) of your tests*	*Treatments*	*Describe the treatment – did it help?*
□ X-ray	_____	□ Medications	_____
□ MRI	_____	□ Injections	_____
□ CT scan	_____	□ Surgery	_____
□ Bone scan	_____	□ Physical therapy	_____
□ Ultrasound	_____	□ Bracing	_____
□ Other	_____	□ Other	_____

Medical History

Has there been any change in your health, e.g., new diagnoses, recent/upcoming surgeries? _____

_____

Females only – Do you think you might be pregnant at this time? □ Yes □ No

Social History

Has there been any change in your life, e.g., major events, new job, recent/upcoming travel, etc.? _____

_____

Review of Systems

Please check any symptom below that you are currently experiencing or have experienced in the past few weeks:

Abdominal pain	□ Yes	□ No	Fever/chills	□ Yes	□ No
Anxiety/depression	□ Yes	□ No	Heartburn	□ Yes	□ No
Balance problem	□ Yes	□ No	Rash	□ Yes	□ No
Chest pain	□ Yes	□ No	Skin infection	□ Yes	□ No
Easy bruising	□ Yes	□ No	Weight loss	□ Yes	□ No

What goals do you have for today's visit? _____

_____

_____

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____