HSS HOSPITAL FOR SPECIAL SURGERY

FOLLOW-UP VISIT

SAME PROBLEM

Brett Toresdahl, MD

Name: ________________________ Age: ________ Today's Date: ______________

Current Problem: ____

Which side is affected? ☐ Right ☐ Left ☐ Both

How have your symptoms changed since your last visit? ______________________________

____

What have you done to treat your pain since your last visit? ___________________________

____

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 = none, 10 = extreme):

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? __________

____

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.? __________

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

Review of Systems

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

Symptom			Symptom		
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? ____

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Would you like today's note to be sent to another physician? □ Yes □ No

Name: ______________________ Clinic/Organization: ______________________

Clinic Address: ____

Clinic Phone: ______________________ Clinic Fax: ______________________

Patient Signature: ______________________________ **Date:** ____________________

Physician Signature: ______________________________ **Date:** ____________________