Banner Health®

FOLLOW-UP QUESTIONNAIRE - ORTHOPEDIC

Patient Name: ________________________ DOB: __________ Today's Date: __________

Date of Injury ________________________ Date of Surgery ________________________

PRESENT MEDICAL INFORMATION

What body part is involved? (Please check all that apply below

Ankle:	❑ R	❑ L	Arm:	❑ R	❑ L	Back:	❑		Elbow:	❑ R	❑ L
Finger: ______	❑ R	❑ L	Foot:	❑ R	❑ L	Hand:	❑ R	❑ L	Hip:	❑ R	❑ L
Knee:	❑ R	❑ L	Leg:	❑ R	❑ L	Neck:	❑		Pelvis:	❑	
Shoulder:	❑ R	❑ L	Toe:	❑ R	❑ L	Wrist:	❑ R	❑ L	Other:		

On a scale of 0-100%, how much better are you now? (if not better, put 0%) ________________

On a scale of 0-10 (10 being the worst) how severe is your pain? ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

What is the quality of your pain: ❑ Sharp ❑ Dull ❑ Stabbing ❑ Throbbing ❑ Aching ❑ Burning

What medications are you still taking for this problem? ❑ None ❑ Narcotic: ________________

❑ Anti-Inflammatory: ________________ ❑ Other: ________________

If you had surgery for this condition, on a scale of 0-10 (10 = most pleased), how pleased are you with the outcome of your surgery? ________________________________

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Are there any questions you want the doctor to answer during this visit? ________________________

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I hereby certify that the above information is true and correct to the best of my knowledge.

Patient/ Representative Name: ________________________________

Patient Signature: ________________________ Date: ________________

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