Center for Orthopaedic Surgery and Sports Medicine

7940 FLOYD CURL DRIVE SUITE 560 • SAN ANTONIO, TX 78229
PHONE: (210) 692-7400 • FAX: (210) 692-0090

FOLLOW-UP QUESTIONAIRE

Dr. Ty H. Goletz, M.D. / Uwe R. Pontius, M.D. / Gregory D. Gordon, M.D. / Geoffrey M. Millican, M.D. / Michael L. Jones, M.D.

Patient Name: ____ Today's Date ______________________

What body part is involved? (circle which side)

Shoulder R / L   Elbow R / L   Arm R / L   Wrist R / L   Hand R / L

Fingers R /L   Hip R / L   Knee R / L   Ankle R / L

How long has it been since your last visit? _________________________

Since your last visit, are you:

☐ Feeling Better ☐ Feeling Worse ☐ Feeling the same

On a scale of 0 – 100%, how much better are you now? ___________%

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

How would you describe your pain?
☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning
☐ Other ____
____

Is the pain:
☐ Constant ☐ Intermittent ☐ Wakes me from sleep
☐ Other ____

Do You have:
☐ Swelling ☐ Numbness ☐ Tingling ☐ Weakness ☐ Bruising
☐ Other ____

What medications are you still taking for this condition? ☐ None
☐ Anti-inflammatory ____
☐ Narcotic ____

Are you currently under the care of a pain management physician?
☐ Yes ☐ No Date Care Started ____________________
Physician's Name ____
List Medications prescribed by this physician ______________________
____

**Please note: We do not generally prescribe pain medication for long term use. All pain medications are closely monitored and prescribed on an "as needed" basis.

Have you developed new problems in any of these areas?

☐ Allergies ☐ Nerves ☐ Lungs ☐ Ears ☐ Eyes
☐ Skin ☐ Stomach/Bowels ☐ Diabetes ☐ Urine
☐ Other Joints ☐ Weight Loss ☐ Fever ☐ Heart
☐ Anemia ☐ Psychiatric
☐ Other ______________________________________

Describe any new problems:

____
____
____
____

☐ I have no new problems in these areas.

Have you been prescribed any new medications by another physician? ☐ Yes ☐ No

Have you been hospitalized for a non-orthopedic condition? ☐ Yes ☐ No
Describe: ____________________________________

Do you smoke? ☐ Yes PPD _________ ☐ No

What is your current job status? ☐ Regular job
☐ Light Duty ☐ Do Not Work ☐ Retired
☐ Not working/on disability due to condition

Have you had any Physical Therapy? ☐ Yes ☐ No
Where: ______________________________________
Dates: ____/____/_____ to _____/____/____

Has your pharmacy info changed? ☐ Yes ☐ No
New Pharmacy: ________________________________
Location: ____________________________________
Phone # _____________________________________

The information on this form is accurate and to the best of my knowledge.

______________________________ ____________
Patients Signature **Date**

______________________________ ____________
Physician Signature **Date**