SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES

PATIENT FOLLOW UP INFORMATION:

Name:____ Date of Birth: ___________

HEIGHT:_______ feet ______ inches WEIGHT:________ lbs.

Are your currently working: Yes ___ No ___

If yes, current employer: _________________________________

Why are you here today? ____

____

For each, circle what BEST applies:

The pain is: BETTER SAME WORSE

The pain is: DULL SHARP ACHY THROBBING BURNING OTHER__________

On a 0-10 severity scale (worst = 10) the pain is a: 0 1 2 3 4 5 6 7 8 9 10

What makes it worse? ____

What makes it better? ____

Information below is to update NEW Changes to Medical History since last visit!

*If no new changes please check here and sign form ( ) **No New Changes**
*Are you feeling depressed? **YES ___ NO ___**

NEW Medical, Surgical, Allergies or Smoking History: ( ) NONE

Explain: ____

____

____

____

____

____

Patient or responsible party signature:__________________________________ Date:____________

4/15/21