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? _____

_____

Did the above injury occur as a result from a fall? ___ YES ___ NO

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***

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

Explain: _____

_____

_____

_____

Do you have an advanced care plan? ___ YES ___ NO

Do you have a healthcare proxy? ___ YES ___ NO

Patient or Responsible Party Signature:_____Date:_____

Phone: _____Email: _____