OSS Health
Follow-up Medical Questionnaire

Patient Name (print):_____ Todays Date:_____

DOB:_____ Age:_____ ☐M ☐F ☐O Dominant Hand ☐R ☐L Height:_____ Weight_____

1. What is the reason for this visit? ☐ Follow-up ☐ Fracture ☐ Post-op ☐Other_____

2. What body part is involved? Please check below.

Neck☐ and Radiates to ☐R arm ☐L arm	Shoulder ☐R ☐L	Arm ☐R ☐L	Elbow ☐R ☐L	Wrist ☐R ☐L	Hand ☐R ☐L	Finger ☐R ☐L
Back ☐ and Radiates to ☐R leg ☐L leg	Pelvis ☐R ☐L	Hip ☐R ☐L	Knee ☐R ☐L	Ankle ☐R ☐L	Foot ☐R ☐L	Toe ☐R ☐L

3. Is there a new problem since your last visit? ☐N ☐Y Please describe: _____

4. How long has it been since your last visit? _____☐ Days ☐ Weeks ☐Months

5. Since your last visit, are you: ☐Better ☐Worse ☐Same

6. On a scale of 0-100%, how much better are you now? If no better put 0% _____%

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

8. What is the quality of the pain? ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning ☐_____

9. The pain is now? ☐Constant ☐Comes and goes (intermittent) Does pain wake you from sleep? ☐Y ☐N

10. Do you have? ☐Swelling ☐Bruising ☐Numbness ☐Tingling ☐Weakness ☐ None

11. What medications are you still taking for this condition? ☐ none
☐Anti-inflammatory_____
☐Pain killers_____

12. Use the check box below to show what treatment was done at your last visit?

Treatment	Did it help?
☐Anti-inflammatories	☐Y ☐N
☐Narcotics (pain killers)	☐Y ☐N
☐Brace/cast	☐Y ☐N
☐Physical therapy	☐Y ☐N
☐Home exercise program	☐Y ☐N
☐Injection at last visit	☐Y ☐N
☐Surgery since last visit	☐Y ☐N

13. What is your current job status? ☐ Regular ☐ Light/Restricted duty ☐ not working due to this condition
☐ Do not work/retired ☐ Disabled

14. Do you have any questions you would like answered today?

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