TRI-CITY ORTHOPAEDICS

Dr Shoham Follow Up Visit

Please carefully complete all sections of this form, even if nothing has changed since your last visit

NAME: _____ DOB_____ TODAY'S DATE_____

Reason for Today's Visit

Post-Procedure Assessment
Review Test Results
Review MRI Results
Other_____

Pain Description

Weight: _____ Height: _____

Use the diagram to indicate the location and type of your pain.

Mark the drawing with the following letters that best describe your symptoms:

"B" = burning **"D"** = deep **"DU"** = dull **"E"** = electric
"N" = numbness **"SP"** = sharp **"SH"** = shooting
"S" = stabbing **"B" =** burning **"P" =** pins and needles
"A" = aching **"T"** = "Throbbing"

What number on the pain scale (1-10) best
Describes your worst pain over the last week? _____

Where is your worst area of pain located?

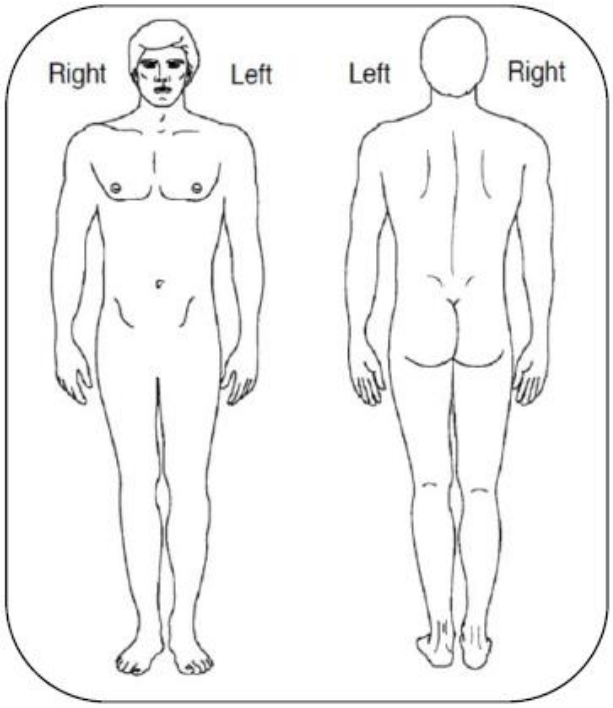
_____

Does this pain radiate? If so where?

_____

Check all that describe your pain today:

□ Aching
□ Cramping
□ Hot/Burning
□ Stabbing/Sharp
□ Shock-like
□ Tingling/Pins and Needles



What word best describes the frequency of your pain? □ Constant □ Intermittent

When is your pain at its worst? □ Mornings □ During the day
□ Evenings □ Middle of the night

What makes your pain better? _____

What makes your pain worse? _____

MARK ALL OF THE FOLLOWING ACTIVITIES THAT ARE ADVERSELY/NEGATIVELY AFFECTED BY YOUR PAIN:

□ Enjoyment of life □ Normal Work □ General Activity □ Recreational Activities
□ Walking □ Mood □Relationships with People
□ Other: _____

Review of Systems

Musculoskeletal:
□ Joint Pain
□ Arthritis
□ Muscular Weakness
□ Stiffness
□ Muscular Pain

Neurological:
□ Headache
□ Dizziness
□ Seizures
□ Loss of Sensation
□ Vertigo

Changes Since Your Last Visit

Have you developed any new pain complaints since your last visit that you would like to discuss today?
□ Yes □ No
Since your last appointment, how has your pain changed?
□ Decreased □ Increased □ Stayed the Same
If you had a procedure, how much pain relief did you obtain?
□ None □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%
Any problems since procedure? □ Yes □ No
If yes please explain: _____

SINCE YOUR LAST VISIT, HAVE YOU DEVELOPED ANY <u>NEW</u>:
□ Balance Problems □ Bladder Incontinence □ Fevers □ Chills
□ Difficulty Walking □ Bowel Incontinence □ Nausea □ Vomiting
Numbness/Tingling-Where? _____ Weakness-Where? _____
□ I HAVE **NOT** DEVELOPED ANY RECENT PROBLEMS WITH ANY OF THE ABOVE CONDITIONS SINCE MY LAST VISIT.

Are you currently taking any blood-thinners or anticoagulants? □ Yes □ No
Please indicate which (if any) of the following blood-thinners you are taking:
□ Aggrenox □ Coumadin/Warfarin □ Effient □ Lovenox □ Plavix □ Pletal □ Pradaxa
□ Prasugrel □ Ticlid □ Other _____

SIGNITURE AND DATE

Signed: _____ Date: _____