PHYSICIANS' CLINIC
of Iowa, P.C.

ORTHOPAEDIC - RECHECK QUESTIONNAIRE

Today's Date _____ Height (feet/inches) _____ Weight (pounds) _____

First Name _____ Last Name _____

Date of Birth _____ Age _____

Reason for visit? ☐ Follow-Up ☐ Follow-Up Fracture ☐ Post-Op

What body part is involved?

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

Is there a new problem that was NOT evaluated at your last visit? ☐ Yes ☐ No If yes, what is it? _____

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

Since your last visit, are you: ☐ Better ☐ Worse ☐ Unchanged

On a scale of 0-100%, how much better are you now? *(If not better at all, note 0%)* _____ %

On a scale of 0-10 how severe is your pain? *(Please circle only one number)*

0 1 2 3 4 5 6 7 8 9 10

No Pain ⟷ Moderate Pain ⟷ Severe Pain

Quality of pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Burning

Timing of pain? ☐ Constant ☐ Comes and Goes Does it wake you at night? ☐ Yes ☐ No

Do you have any of the following?

☐ Numbness ☐ Tingling ☐ Weakness ☐ Swelling ☐ Locking/Catching ☐ Giving Way
☐ Loss of bowel or bladder control ☐ None

Are you still taking medications for this condition? ☐ Yes ☐ No If yes, which ones? _____

Please mark below what treatment(s) you have had at or since your last visit.

Treatment	Did it help?	Treatment	Did it help?
Anti-Inflammatories	☐ Yes ☐ No	Home Exercise Program	☐ Yes ☐ No
Narcotics	☐ Yes ☐ No	Injection at Last Visit	☐ Yes ☐ No
Brace/Cast	☐ Yes ☐ No	Surgery Since Last Visit	☐ Yes ☐ No
Physical or Occupational Therapy	☐ Yes ☐ No		

INTERVAL HISTORY *(since your last visit)*

Have you developed new problems in any of the following areas?

☐ Yes ☐ No Bowels ☐ Yes ☐ No Eyes ☐ Yes ☐ No Nerves ☐ None
☐ Yes ☐ No Diabetes ☐ Yes ☐ No Joints ☐ Yes ☐ No Skin
☐ Yes ☐ No Ears ☐ Yes ☐ No Lungs ☐ Yes ☐ No Urine

Please describe any new problem _____

Have you developed new allergies? ☐ Yes ☐ No If yes, please describe _____

Have you been prescribed new medications by another physician? ☐ Yes ☐ No If yes, which medications? _____

Have you been hospitalized for a non-orthopaedic condition? ☐ Yes ☐ No If yes, please describe _____

Have you started or stopped smoking? ☐ Yes ☐ No If yes, please describe _____

What is your current job status? ☐ Regular Job ☐ Light Duty ☐ Not working, due to condition ☐ Do not work

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____