TAMPA BAY ORTHOPAEDIC SPECIALISTS

FOLLOW UP
David T Braun MD

Patient Name *(Please Print)* _____ Date of Birth _____

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

What body part is involved? (Location)																					
Neck ☐		Shoulder	☐ Right ☐ Left	Elbow	☐ Right ☐ Left	Hand	☐ Right ☐ Left	Pelvis	☐ Right ☐ Left	Knee	☐ Right ☐ Left	Foot	☐ Right ☐ Left
Back	☐ Mid ☐ Lower	Arm	☐ Right ☐ Left	Wrist	☐ Right ☐ Left	Finger	☐ Right ☐ Left	Hip	☐ Right ☐ Left	Ankle	☐ Right ☐ Left	Toe	☐ Right ☐ Left

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

On a scale of 0-100%, how much better are you now than you were when your problem was at its worst? _____

How severe is our pain now? ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe

What has been done for you since your last visit?

Treatment	Has this helped?			Comments:
☐ Anti-inflammatories	☐ Yes	☐ No	_____ *(Name)*	_____
☐ Narcotics	☐ Yes	☐ No	_____ *(Name)*	_____
☐ Brace/Cast	☐ Yes	☐ No		_____
☐ Crutch	☐ Yes	☐ No		_____
☐ Physical Therapy	☐ Yes	☐ No		_____
☐ Injection	☐ Yes	☐ No		_____
☐ Surgery	☐ Yes	☐ No		_____

Since your last visit, has your medical history changed?

Have you felt any new ☐ Numbness ☐ Swelling ☐ Tingling ☐ Weakness(MS ROS) ☐ Joint pain ☐ Catching/ Locking

Developed new problems in any of these areas? ☐ Eyes ☐ Ears ☐ Heart ☐ Lungs ☐ Bowels ☐ Urine ☐ Skin ☐ Diabetes ☐ Joint ☐ Nerves

Describe: _____

Taken new medication? ☐ Yes ☐ No Describe: _____

Developed new allergies? ☐ Yes ☐ No Describe: _____

Started or stopped smoking? ☐ Yes ☐ No Describe: _____

ARE THERE ANY QUESTIONS YOU WANT THE DOCTOR TO ANSWER FOR YOU AT THIS VISIT? _____