Orthopaedic & Spine Surgery Institute
19450 Deerfield Avenue , Suite 300
Leesburg, VA 20176
O: 703-723-6774 (OSSI)
F: 703-723-1494
www.OSSI-Virginia.com

Patient Follow-Up Form

Last Name: _____ **First Name:** _____ **Date:** ____/____/____

Sex: ___ **Male** ___ **Female** **Date of Birth:** ____/____/____ **Height:** _____ **Weight:** _____ **Temp:** _____ **(staff use)**

Preferred Pharmacy: _____ **Phone:** _____

Current Address (if changed since last visit): _____

Are you currently residing in a Nursing/Rehab Facility? _____ **Yes** _____ **No**

If yes, please provide the name of the facility: _____

Has your insurance changed since your last visit? ☐ **Yes** ☐ **No**

****If you checked yes, PLEASE PROVIDE YOUR NEW INSURANCE CARD TO A RECEPTIONIST AT CHECK IN****

History of Present Illness:

Chief Complaint: _____

Date of Injury/Onset: ____/____/____ Secondary to : ☐ Illness ☐ Accident ☐ Work ☐ Chronic ☐ Other

How often do you have this pain? ☐ Constant ☐ Intermittently ☐ Episodic

Please describe your pain: ☐ Dull ☐ Ache ☐ Sharp ☐ Shooting ☐ Burning ☐ Stabbing

On a scale of 0 to 10 (0 = no pain; 10 = most unbearable pain), what is your pain score? ____ without activity ____ with activity

How is your pain since your last visit? ☐ Improving ☐ Unchanged ☐ Worsening

Indicate how your symptoms respond to following?

Standing	☐ Relieves	☐ Worsens	☐ No Difference
Sitting	☐ Relieves	☐ Worsens	☐ No Difference
Lying Down	☐ Relieves	☐ Worsens	☐ No Difference
Stretching/Exercise	☐ Relieves	☐ Worsens	☐ No Difference

Other (please specify): _____

What treatments have you tried thus far and how much relief have you received from them?

Medications	☐ Excellent relief	☐ Moderate relief	☐ No relief	☐ Have not tried
Heat/Ice	☐ Excellent relief	☐ Moderate relief	☐ No relief	☐ Have not tried
Physical Therapy	☐ Excellent relief	☐ Moderate relief	☐ No relief	☐ Have not tried
Injections	☐ Excellent relief	☐ Moderate relief	☐ No relief	☐ Have not tried
Chiropractor	☐ Excellent relief	☐ Moderate relief	☐ No relief	☐ Have not tried

Have there been any changes to your current medical and/or surgical history since your last visit? ☐ **Yes** ☐ **No**

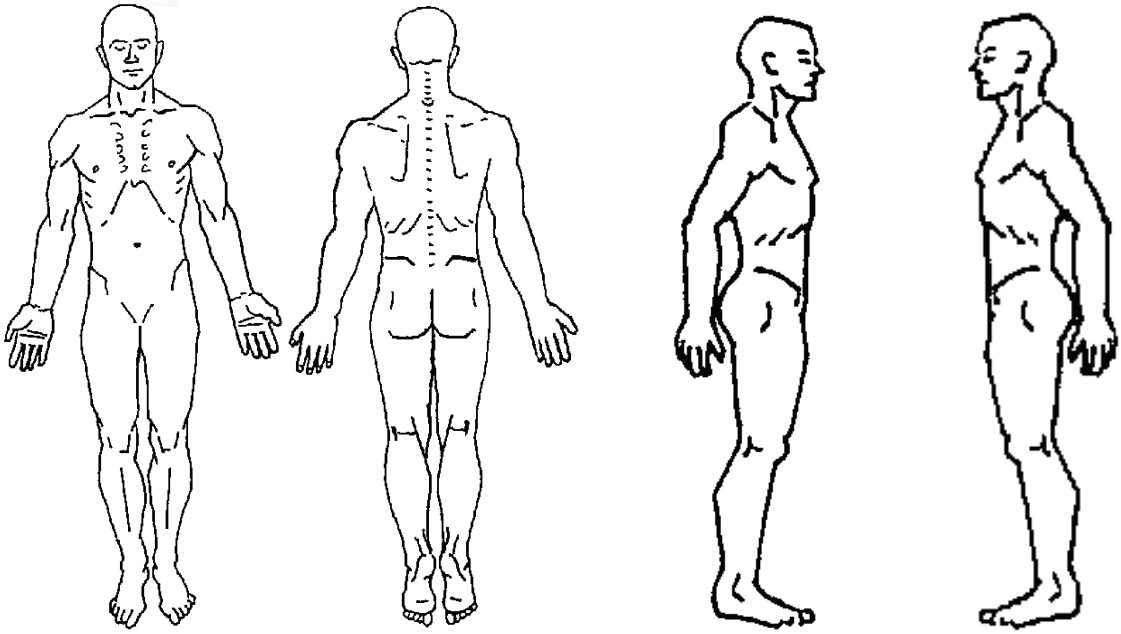
If yes, please specify: _____

Any new medications or allergies? ☐ **Yes** ☐ **No**

Please Complete Both Sides

Location of Pain/Injury: *(Please write and mark figures below)*

Orthopaedic & Spine Surgery Institute
19450 Deerfield Avenue , Suite 300
Leesburg, VA 20176
O: 703-723-6774 (OSSI)
F: 703-723-1494
www.OSSI-Virginia.com



Review of Symptoms:

(Please check all the following symptoms if they apply to you recently)

General:	☐ Change in weight, ☐ Appetite, ☐ Sleep, ☐ Taste/Smell ☐ Fatigue ☐ Fever
Skin:	☐ Rash ☐ Itching
Head & Neck:	☐ Dizziness ☐ Balance Problems ☐ Vision/Eye Problems ☐ Hoarseness ☐ Trouble Swallowing
Pulmonary:	☐ Chronic cough ☐ Emphysema ☐ Tuberculosis ☐ Bronchitis
Cardiovascular:	☐ High Blood Pressure ☐ Chest pain ☐ Heart Attack ☐ Shortness of Breath ☐ Blood Clots (DVT)
Gastrointestinal:	☐ Stomach ulcers ☐ Stomach bleed ☐ Heartburn ☐ Diarrhea ☐ Constipation
Urinary:	☐ Kidney Stone ☐ Kidney Infections ☐ Painful Urination ☐ Incontinence ☐ Bleeding
Reproductive:	☐ Sexually transmitted diseases ☐ Bleeding ☐ Impotence
Hematologic/Lymphatic:	☐ HIV or AIDS ☐ Lymphoma ☐ Bleeding problems ☐ Sickle cell disease
Musculoskeletal:	☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Back pain ☐ Neck pain ☐ Joint pain ☐ Muscle disorder
Neurological:	☐ Fainting ☐ Headache ☐ Seizure ☐ Memory loss ☐ Dizziness ☐ Numbness

Patient Signature: _____ Date: ____/____/_____

CC: _____ (staff use only)