**Orthopaedic & Spine Surgery Institute**
19450 Deerfield Avenue, Suite 300
Lansdowne, 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** **Age:** _____ **Date of Birth:** ____/____/____ **Height:** _____ **Weight:** _____

**Preferred Pharmacy:** _____ **Referring physician** _____**R.R.**____ **staff only**

**Are you currently residing in a Nursing/Rehab facility?** _____**Name of the facility:** _____

**Current address (if changed since last visit):**_____

**Phone:**_____**Insurance (if different from last visit):**_____

## History of Present Illness

Chief Complaint? _____

_____

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

Describe how the injury happened: *(Be specific)*

_____

_____

**How often do you have this pain?** *(Check one only)* ☐ Constantly ☐ Intermittently

**What is the quality of the pain?** ☐ Aching ☐ Throbbing ☐ 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

**Is your pain better since last time:** ☐ Yes ☐ No

**What makes your pain better?** *(e.g., Heat, cold, sitting, lying down, standing, stretching, PT, medications)*

_____

_____

**What makes your pain worse?** *(e.g. Bending, lifting, specific activities, sitting, standing) (Be specific)*

_____

_____

**Have there been any new medical or surgical problems since your last visit? Any new medications or allergies?**

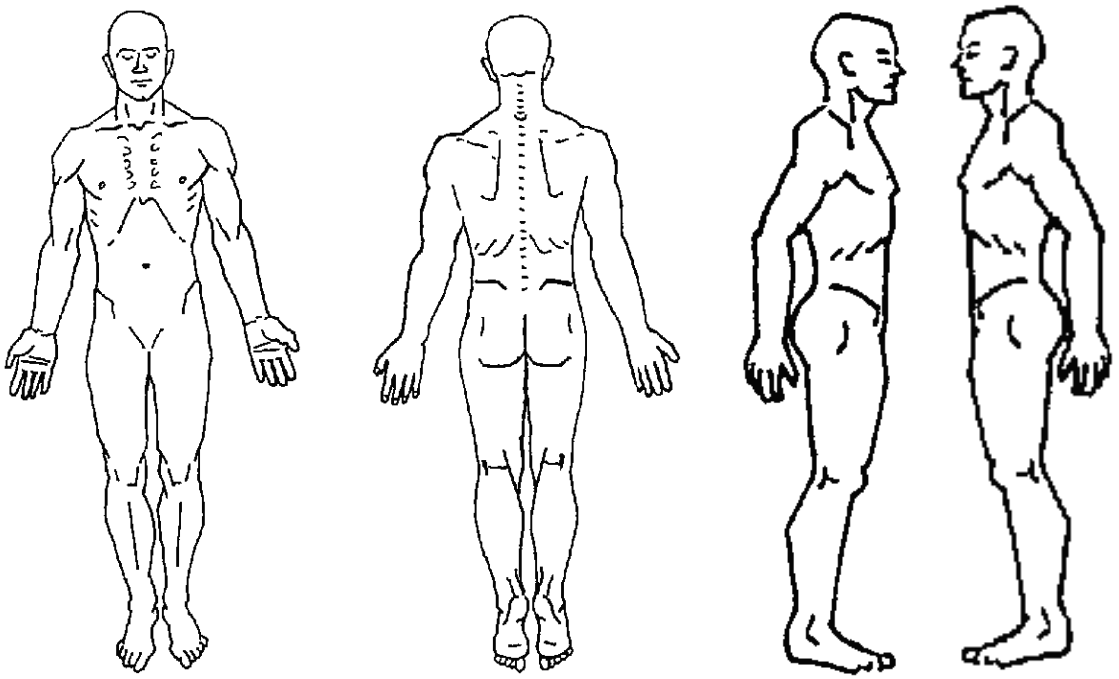
_____

_____

**Please turn over to continue on backside**

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

**Location of Pain/Injury:** *(Please write and mark figures below)*
*Using the following legend, add the letter that corresponds to the type of pain you are having to the body diagram below. Be sure to mark all areas where the pain is located.*



| Type of Pain | Symbol |
|---|---|
| Aching | AAA |
| Numbness | NNN |
| Pins & Needles | PPP |
| Burning | BBB |
| Stabbing | SSS |

**Where is the worst pain out of 100%?**
Neck pain ____% VS. Arm pain ____%
Back pain ____% VS. Leg pain ____%

## Review of Systems: (Please check as many as needed and provide explanation if needed)

**General:** ☐ Change in weight, ☐ Appetite, ☐ Sleep, ☐ Taste or Smell, ☐ Fatigue, ☐ Fever

**Skin**: ☐ Rash, ☐ Itching

**Head & Neck**: ☐ Dizziness, ☐ Balance problems, ☐ Vision & eye problems, ☐ Hoarseness, ☐ Difficulty swallowing

**Lungs**: ☐ 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 Tract**: ☐ Kidney stone, ☐ Kidney infections, ☐ Painful urination, ☐ Incontinence, ☐ Bleeding

**Reproductive System**: ☐ Sexually transmitted diseases, ☐ Bleeding, ☐ Impotence

**Blood & Lymphatics**: ☐ HIV or AIDS, ☐ Lymphoma, ☐ Bleeding problems, ☐ Sickle cell disease

**Musculoskeletal System**: ☐ Osteoarthritis, ☐ Rheumatoid arthritis, ☐ Back pain,

☐ Neck Pain ☐ Joint pain, ☐ Muscle disorder

**Nervous System**: ☐ Fainting, ☐ Headache, ☐ Seizure, ☐ Memory loss, ☐ Dizziness, ☐ Numbness

**Smoker Status:** ☐ **current smoker** ☐ **former smoker** ☐ **never smoked**

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

**Patient Signature:** _____ **Date:** _____/_____/_____
CC: _____