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New York Queens Medicine & Surgery, PC
Orthopaedics & Rehabilitation

UPDATE FOR NEW CONDITION/INJURY

Patient Name: _____ Date: _____

Reason for visit:
- ❑ F/U visit
- ❑ F/U fracture
- ❑ Post-op (Date of Surgery: _____)
- ❑ New problem (please describe briefly below):
- ❑ Review MRI or other studies
- ❑ Injection
- ❑ Cast Removal

_____

What body part is involved? (Please mark the table below)

SHOULDER/ARM ❑L ❑R	HIP/GROIN/THIGH ❑L ❑R	NECK/UPPER BACK ❑
ELBOW ❑L ❑R	KNEE ❑L ❑R	MID-BACK ❑
FOREARM/WRIST ❑L ❑R	LEG/ANKLE ❑L ❑R	LOWER BACK ❑
HAND/FINGERS ❑L ❑R	FOOT/TOES ❑L ❑R	

1. How long has it been since your last visit? _____ ❑ Days ❑Weeks ❑ Months
2. Since your last visit, are you: ❑ resolved ❑ better ❑ worse ❑ same
3. On a scale of 0-100%, how much better are you now? _____ % (If not better, put 0%)
4. On a scale of 0-10 (10 is the worst), how severe is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10
5. What is the quality of the pain? ❑ sharp ❑ dull ❑ stabbing ❑ throbbing ❑ aching ❑ burning
6. The pain is now: ❑ constant ❑ comes and goes (intermittent) Does your pain wake your up from sleep? ❑ Y ❑ N
7. Do you have: ❑ numbness ❑ tingling ❑ weakness ❑ swelling ❑ locking/catching ❑ giving way
   ❑ loss of control of bowel or bladder ❑ none
8. What medications are you still taking for this condition: ❑ none
   ❑ anti-inflammatory _____
   ❑ narcotic (pain killer) _____
9. Please indicate if you have had any diagnostic tests/evaluations since your last visit:
   ❑ MRI ❑ CT scan ❑ Nuclear scan ❑ Ultrasound ❑ X-rays
   ❑ EMG ❑ Blood work ❑ Evaluation by another doctor: _____

10. Use check box below to show what treatment was done at or since your last visit:

Treatment	Did it help?
❑ Anti-inflammatories	❑ Yes ❑ No
❑ Narcotics	❑ Yes ❑ No
❑ Brace/Cast	❑ Yes ❑ No
❑ Physical/Occupational Therapy	❑ Yes ❑ No
❑ Home Exercise Program	❑ Yes ❑ No
❑ Injection at last visit: short term	❑ Yes ❑ No
❑ Injection at last visit: long term	❑Yes ❑ No
❑ Surgery since last visit	❑ Yes ❑ No

REVIEW OF SYMPTOMS

Interval History
Since the last visit, have you:

Developed new problems in:

Eyes ❑ Y ❑ N	Heart ❑ Y ❑ N	Bowels ❑ Y ❑ N
Skin ❑ Y ❑ N	Ears ❑ Y ❑ N	Lungs ❑ Y ❑ N
Urine ❑ Y ❑ N	Nerves ❑ Y ❑ N	Diabetes ❑ Y ❑ N
Joints ❑ Y ❑ N	❑ None	

Developed new allergies? ❑ Y ❑ N If yes, please describe: _____

PMH
Been prescribed new medications by any other physician? ❑ Y ❑ N If yes, please describe:
_____
_____
_____

Been hospitalized for a non-orthopaedic condition? ❑ Y ❑ N If yes, please describe:
_____
_____
_____

SH
Started or stopped smoking? ❑ Y ❑ N If yes, please describe: _____

Please indicate whether you're currently:

❑ Working full-time	❑ Working part-time	❑ Unemployed	❑ Retired
❑ On temporary disability	❑ On permanent disability	❑ In school	

What is the current job status? ❑ regular job ❑ light duty ❑ not working due to this condition

Are there any questions you wish your doctor to answer for you at this visit? _____
_____
_____

By signing below you indicate your understanding that it is your responsibility to provide complete and accurate information about your health history and current condition, including information about any changes since the last visit.

Patient Signature: _____ Date: _____