HOSPITAL FOR SPECIAL SURGERY

FOLLOW–UP VISIT FORM **PHYSICIAN: ALEX SIMOTAS, MD**

NAME OF PATIENT: ______________________________ AGE ______ DATE: / /

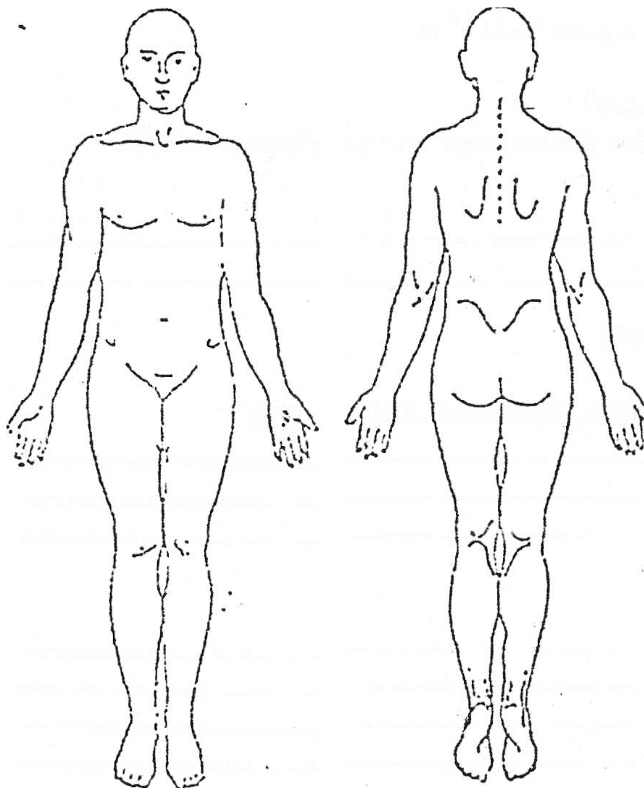
Are you currently working ? ☐ Yes ☐ NO ☐ Full-time ☐ Part-time ☐ Limited Duty?

Are you currently in Physical Therapy? ☐ Yes ☐ No

List your complaints in order of importance for today's visit. Is it better, same, or unchanged?

	Nature of complaint (indicate if new problem)	**Better**	**Same**	**Worse**	**% Change (from last visit)**
1	______________________________	☐	☐	☐	______________
2	______________________________	☐	☐	☐	______________
3	______________________________	☐	☐	☐	______________

Please complete the pain diagram: place **X** marks where you have pain. Write in **NNN** in areas where you have numbness, or pins and needles. Mark a large **X** where you feel the worst pain.



Circle your current level of pain

No pain = 0 ………… Extreme pain = 10

Neck	1	2	3	4	5	6	7	8	9	10
Right arm	1	2	3	4	5	6	7	8	9	10
Left arm	1	2	3	4	5	6	7	8	9	10
Back	1	2	3	4	5	6	7	8	9	10
Right leg	1	2	3	4	5	6	7	8	9	10
Left leg	1	2	3	4	5	6	7	8	9	10

MEDICATIONS (please list all current meds): ____

____

Medical Problems	**New**	**Update (if a previous problem)**	**Treatment**
______________	☐	______________________________	______________
______________	☐	______________________________	______________

Please go to the next page

REVIEW OF SYSTEMS: Check conditions that apply, make other remarks in the space provided, **or** mark ☐ None

NEUROLOGICAL: ☐ New Numbness ☐ Weakness of Arm or Leg Muscle ☐ Clumsy Hands	Other ________________	☐ None
CARDIOVASCULAR: ☐ Heart Trouble ☐ Chest Pain ☐ Murmur ☐ High Blood Pressure ☐ Shortness of Breath ☐ Poor Circulation ☐ Swelling of Legs/Ankles	Other ________________	☐ None
RESPIRATORY: ☐ Chronic Cough ☐ Asthma ☐ Bronchitis ☐ COPD	Other ________________	☐ None
GASTROINTESTINAL: ☐ Ulcers ☐ Gastritis ☐ Diverticulitis ☐ Gall Stones ☐ Stomach or Abdominal Pain	Other ________________	☐ None
MUSCULOSKELETAL: ☐ Other Joint Problems ☐ Swelling ☐ Muscle Pains	Other ________________	☐ None
ENDOCRINE: ☐ Thyroid Trouble ☐ Diabetes	Other ________________	☐ None
HEMATOLOGIC: ☐ Anemia ☐ Enlarged Lymph Nodes ☐ Blood Disorder	Other ________________	☐ None
PSYCHIATRIC: ☐ Excess Anxiety ☐ Tension ☐ Depression	Other ________________	☐ None

-------------------------------------- PHYSICIAN WORKSHEET: DO NOT COMPLETE --------------------------------------

Hx Notes:

PMH:

Meds:

BP Pulse Weight Height

Examination Findings:

Radiographic Findings:

Impression:

Plan: