Follow-up Questionnaire

These questions are intended to help us provide better care to you. Thank you.

Patient Name _____ Today's Date _____

I am here for a follow-up appointment for my (ie: right knee) _____

1. When were you seen last? Days ____ or Weeks ____ or Months ____ **Height** ____ **Weight** ____
2. Since your last visit, are you... ○ Same ○ Worse ○ Better From 0-100%, how much better? ____
3. If you are still having pain, how severe is it? ○ Mild ○ Moderate ○ Severe ○ Extremely Severe
4. Is the pain now... ○ constant ○ intermittent (comes & goes)
5. Please indicate <u>which treatments</u> you have had since your last visit....

Prescription Anti-inflammatory medicine	☐ Helped	☐ Did not help	Which medicine? ____
Over-the-counter Anti-inflammatory	☐ Helped	☐ Did not help	Which medicine? ____
Brace, Splint, Shoe Insert, or Cast	☐ Helped	☐ Did not help	Which one? ____
I did the exercises at home as given to me	☐ Helped	☐ Did not help	How many times? ____
I went to physical therapy	☐ Helped	☐ Did not help	How many times? ____
I received an injection	☐ Helped	☐ Did not help	Which medicine? ____

<u>SINCE YOUR LAST VISIT HERE</u>

6. Have any of your OTHER JOINTS become swollen or painful? ○ Yes ○ No
7. Have you had any NEW SYMPTOMS (check all that apply) ☐ Numbness ☐ Tingling ☐ Weakness
8. Have you developed any OTHER SYMPTOMS (check all that apply)

   ☐ Stomach Ache ☐ Nausea/vomiting ☐ Blood in Stool
9. Have you developed any NEW medical conditions? ○ Yes ○ No

   If yes, please explain _____
10. Have you required any operations? ○ Yes ○ No LIST _____
11. Have you developed any NEW Allergies? ○ Yes ○ No LIST _____
12. Are you taking any NEW medicines? ○ Yes ○ No LIST _____
13. Have you started or stopped smoking cigarettes or drinking alcohol? ○ Yes ○ No
14. Have you changed your job? ○ Yes ○ No New Job _____
15. Any other questions for Dr. Longobardi? _____

Patient Signature: _____ Date ____

Physician Signature: _____ Date ____

University Orthopaedic Center | Holy Name Physician Network

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General Orthopaedic Surgery • Sports Medicine and Athletic Injuries • Reconstructive Surgery of Shoulder and Knee

EQ-5D Health Questionnaire

Name: _____ Date: _____

Instructions: Please check only one of the boxes in each group that indicates today's best health state.

Mobility

- I have no problems walking ❑
- I have some problems walking ❑
- I am confined to bed ❑

Self-care

- I have no problems with self-care ❑
- I have some problems washing or dressing myself ❑
- I am unable to wash or dress myself ❑

Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problems performing my usual activities ❑
- I have some problems performing my usual activities ❑
- I am unable to perform my usual activities ❑

Pain/Discomfort

- I have no pain or discomfort ❑
- I have moderate pain or discomfort ❑
- I have extreme pain or discomfort ❑

Anxiety/Depression

- I am not anxious or depressed ❑
- I am moderately anxious or depressed ❑
- I am extremely anxious or depressed ❑