HOSPITAL FOR SPECIAL SURGERY
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Follow-Up Visit

Today's Date: _____

Name: _____ Age: _____ DOB: _____

Have there been any changes in your symptoms? Yes No

Describe any changes:

Have you had any of the following tests or treatments for this problem? (please check)

Test:	*Date(s) of your tests*	*Treatment Type:*	
☐ X-RAY	_____	☐ MEDICATIONS	_____
☐ MRI	_____	☐ INJECTIONS	_____
☐ CT SCAN	_____	☐ HOME EXERCISE	_____
☐ Nerve Tests	_____	☐ PHYSICAL THERAPY	_____
☐ OTHER TESTS	_____	☐ BRACING	_____

Overall, what percentage (%) do you feel better? _____%

Rate Your Pain on a Scale of 0-10 *(0 = No Pain 10 = Extreme Pain):*

Right Now: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

At Worst: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have there been any changes to your health? Yes No

If yes please list them below:

_____

Are you taking any new medications: Yes No

If yes please list them below:

Please list any specific questions you would like addressed today.