Physician Associates – Dr. Marc Grossman

FOLLOW-UP QUESTIONNAIRE

Name: _____ Date of Birth: ____/____/_____ Age: _____

How long has it been since your last office visit? _____

What body part is involved? _____ O Right O Left O Bilateral

Compare your present symptoms to those at your last office visit. O Better O Worse O Same

Which symptoms do you now experience? O Pain O Weakness O Numbness O Tingling O Clicking O Instability O Catching O Swelling

Which of the below treatments have you had since your last office visit?

Treatment	Benefit	Comments
Medications	O Yes O No	
Bracing	O Yes O No	
Physical Therapy	O Yes O No	
Home exercise program	O Yes O No	
Injection	O Yes O No	
Other	O Yes O No	

Updated Medical History:

Please list any new diagnoses since your last office visit. _____

Please list any surgeries since you last office visit. _____

Please list any new medications since your last office visit. _____

Review of Systems: Please check any symptoms you have recently experienced.

Constitutional: O Fever O Weightloss O Headache	Musculoskeletal: O Back pain O Neck Pain O Joint Pain
Eyes: O Worsening vision O Double vision	Neurologic: O Seizures O Tremors O Dizzy
Respiratory: O Shortness of Breath O Wheezing O Frequent Cough	Endocrine: O Excessive thirst O Temperature Sensitivity O Fatigue
Cardiovascular: O Chest Pain O Irregular heartbeat O Leg swelling	Hematology/Lymphatic: O Swollen glands O Blood clotting problem
Immunological: O Drug Allergies	Skin: O Rash O Boils O Persistent itch
Gastrointestinal: O Nausea O Abdominal Pain O Indigestion/Heartburn	Urologic: O Urgency O Frequency O Hematuria O Pain
ENT: O Poor Hearing O Sinus problems O Sore throat	Psychological: O Depression O Anxiety

Patient Signature _____ Date _____

Doctor Signature _____ Date _____