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? _____ ◯ Right ◯ Left ◯ Bilateral

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

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

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

Treatment	Benefit	Comments
Medications	◯ Yes ◯ No	
Bracing	◯ Yes ◯ No	
Physical Therapy	◯ Yes ◯ No	
Home exercise program	◯ Yes ◯ No	
Injection	◯ Yes ◯ No	
Other	◯ Yes ◯ 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: ◯ Fever ◯ Weightloss ◯ Headache	Musculoskeletal: ◯ Back pain ◯ Neck Pain ◯ Joint Pain
Eyes: ◯ Worsening vision ◯ Double vision	Neurologic: ◯ Seizures ◯ Tremors ◯ Dizzy
Respiratory: ◯ Shortness of Breath ◯ Wheezing ◯ Frequent Cough	Endocrine: ◯ Excessive thirst ◯ Temperature Sensitivity ◯ Fatigue
Cardiovascular: ◯ Chest Pain ◯ Irregular heartbeat ◯ Leg swelling	Hematology/Lymphatic: ◯ Swollen glands ◯ Blood clotting problem
Immunological: ◯ Drug Allergies	Skin: ◯ Rash ◯ Boils ◯ Persistent itch
Gastrointestinal: ◯ Nausea ◯ Abdominal Pain ◯ Indigestion/Heartburn	Urologic: ◯ Urgency ◯ Frequency ◯ Hematuria ◯ Pain
ENT: ◯ Poor Hearing ◯ Sinus problems ◯ Sore throat	Psychological: ◯ Depression ◯ Anxiety

Patient Signature _____ Date _____
Doctor Signature _____ Date _____