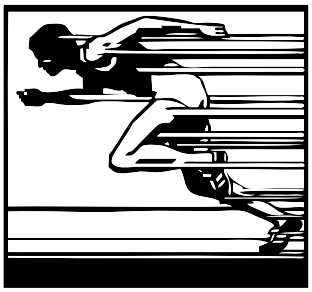

Sports Occupational & Knee Surgery, P.A.

Peter F. Holmes, M.D.

Diplomate of American Board of Orthopaedic Surgery
Fellow American Academy of Orthopaedic Surgery

Kathren Mccarty DPM
Diplomate Of The American Board Of Podiatric Surgery
Fellow American College Of Foot & Ankle Surgeons

Follow-Up Questionnaire

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

PATIENT NAME (PRINT): _____ TODAY'S DATE _____

I AM HERE FOR A FOLLOW-UP APPOINTMENT FOR MY (EX.RT KNEE) _____

or

I HAVE A NEW PROBLEM (INDICATE NEW BODY PART) _____

1. WHEN WERE YOU SEEN LAST? ___DAYS OR ___ WEEKS OR ___ MONTHS

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 ❑ CONSTANT ❑ INTERMITTENT (comes and goes)

5. PLEASE INDICATE WHICH TREATMENTS 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 at home exercises as given to me	❑ HELPED	❑ DID NOT HELP	HOW MANY _____
I went to physical therapy	❑ HELPED	❑ DID NOT HELP	HOW MANY _____
I received an injection	❑ HELPED	❑ DID NOT HELP	WHERE GIVEN _____

SINCE YOUR LAST VISIT HERE

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 **NEW** (CHECK ALL THAT APPLY) ❑ NAUSEA/VOMITING ❑ STOMACH ACHE

9. HAVE YOU DEVELOPED ANY **NEW** ALLERGIES? (CHECK ALL THAT APPLY) ❑ YES ❑ NO IF SO, LIST _____

10. ARE YOU TAKING ANY NEW MEDICINES? ❑ YES ❑ NO IF SO, LIST _____

11. ❑ **STOPPED** SMOKING CIGARETTES ❑ **STOPPED** DRINKING ALCOHOL ❑ Started Smoking ❑ Started Using Alcohol

12. HAVE YOU CHANGED YOUR JOB? ❑ YES ❑ NO

13. ANY OTHER QUESTIONS FOR THE DOCTOR?

_____

_____

_____

PATIENT SIGNATURE _____ DATE _____

PHYSICIAN SIGNATURE _____ DATE _____

9150 Huebner Road, Suite 200 • San Antonio, Texas 78240-1501 • Telephone (210) 696-9000 • Fax (210) 696-9012
Satellite Office: 6051 FM 3009 • Schertz TX 78154-3236