ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

PATIENT INFORMATION
FOLLOW-UP VISIT

TODAY'S DATE

GENERAL INFO

NAME			AGE	DATE OF BIRTH
GENDER ◯ MALE ◯ FEMALE	HEIGHT	WEIGHT	PREFERRED LANGUAGE	
REFERRING PHYSICIAN			PHONE	
ADDRESS				
PRIMARY CARE PHYSICIAN			PHONE	
ADDRESS				
PHARMACY NAME			PHONE	
ADDRESS				

REASON FOR VISIT

WHAT IS THE REASON FOR OUR VISIT TODAY?	
LOCATION OF PAIN (INCLUDE SIDE)	HOW LONG HAS IT BEEN PRESENT?
DESCRIBE PAIN ◯ DULL ◯ SHARP ◯ TINGLING ◯ OTHER:	WHEN DOES PAIN OCCUR? ◯ AT REST ◯ W/ ACTIVITY ◯ AT NIGHT ◯ OTHER:
ANY OTHER SYMPTOMS ASSOCIATED WITH CURRENT PROBLEM?	
SEVERITY: ON A SCALE FROM 1-10, INDICATE HOW SEVERE THE PAIN IS — 1 BEING VERY LITTLE TO 10 BEING EXCRUCIATING/CAN'T FUNCTION. CIRCLE NUMBER: 1 2 3 4 5 6 7 8 9 10	
CONTEXT: HOW DID IT OCCUR?	
DATE OF INJURY	INDICATE WHAT MAKES IT BETTER ◯ ICE ◯ HEAT ◯ REST ◯ ELEVATION ◯ NONE
HAVE YOU BEEN TREATED BY ANOTHER PHYSICIAN FOR THIS COMPLAINT? ◯ YES ◯ NO	

SIGNATURE (PERSON COMPLETING FORM)	DATE COMPLETED

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