Orthopedic Associates of Long Island, LLP
Follow Up Visit History Form

Name: _____ DOB: _____ Date:_____

Were you referred by a physician? Y/N

Physician Name: _____Physician Phone: _____

Are you currently working? Yes _____ No_____ Partial/Light Duty _____ Full Duty _____

What body part are you being seen for today? _____

Since your last visit have you had any **New injuries**? _____

If so when did they start? _____What are your limitations?_____

Since your last visit have you had any Surgeries? Please List:
_____
_____

Since your last visits have you been placed on any new Medications? Please List:
_____
_____

Do you have any Allergies to Medications? _____
_____

ROS: Are you having problems with any of the following?
Eyes: Visual Disturbance Y ___ N ___
Ear/Nose/Throat: Sore Throat Y ___ N __
Respiratory: Shortness of Breath (Dyspnea) Y ___ N ___
Constitutional: Recent Weight Loss Y___ N___
Chills Y ___ N___ Fever Y___ N ___
Psychiatric: Depression Y __ N __ Eating Disorder Y __ N __
Musculoskeletal: Joint Pain Y __ N __ Stiffness Y __ N __ Swelling Y __ N __
Hematologic/Lymphatic: Abnormal Bleeding and Bruising Y __ N __ Anemia Y __ N __
Genitourinary/Nephrology: Urinary/Bowel Incontinence Y __ N __
Cardiovascular: Chest Pain/Pressure Y __ N __
Gastrointestinal: Stomach Burning Y __ N __
Neurologic: Tingling or Numbness Y __ N __
Dermatologic: Rash Y __ N __
Endocrine: Thyroid Nodule Y __ N __
Allergy/Immunology: Hives Y __ N __

Explain Yes responses: _____
_____
_____

Completed by: (sign)_____ Reviewed by: **Dr.** _____

Office Use Only ---------- H:_____ W:_____ T:_____

Update 10/10