Robert S. Rice, MD
Orthopaedic, Surgery & Sports Medicine
2121 North 1700 West
Layton, UT 84041
801-773-4840
www.tannerclinic.com

ORTHOPAEDIC FOLLOW-UP SURVEY

Patient Name: ____ Date: ____________________

Height (Inches): ___________ Weight (Lbs): __________________ Pulse: __________________

1. Did you bring X-rays and/or MRI? (circle one) **Yes/No**
2. How long has it been since your last visit? _________ ☐ Days ☐ Weeks ☐ Months
3. Since your last visit, are you (circle one) **Better / Worse / Same** Please Explain:

____

4. On a scale from 0-100%, how much *BETTER* are you now? _______ %
5. How *SEVERE* is your pain now? (circle one) Mild/Moderate/Severe/Extremely Severe
6. What has been done for you since your *LAST* visit?

Treatment (circle all that apply)	Has This Helped?	Comments
Anti-Inflammatory	Yes/No	___________________ (name)
Narcotics	Yes/No	___________________ (name)
Brace/Cast	Yes/No	
Physical Therapy	Yes/No	
Injection(s)	Yes/No	
Other	Yes/No	___________________ (please list)

7. INTERVAL HISTORY: Since your ***LAST*** visit, have you:
   a. Felt any ***NEW*** (circle all that apply): NUMBNESS/TINGLING/SWELLING/WEAKNESS/NONE
   b. Developed ***NEW*** (circle all that apply): ALLERGIES/NAUSEA/VOMITING/BLOOD IN STOOL/NONE
   c. Taken any ***NEW*** medications? **YES/NO** List Name(s) if yes: _________________________________
   d. Do you use tobacco products? **YES/NO** List Names(s) if yes: _________________________________
8. Are there any questions you want the doctor to answer for you during this visit? **YES/NO** If yes, please list:

____
____
____

Patient Signature ____