

**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**