Cadillac Orthopaedics Followup ***Cast or Splint*** Questionnaire

Appointment Date: _____ Chart# _____ Doctor ☐ B ☐ K

Patient Name (Print): _____ **Date of injury**_____

What body part is broken or injured? **Date of first cast/splint**_____

Shoulder ☐R ☐L	Elbow ☐R ☐L	Wrist ☐R ☐L	Thumb ☐R ☐L	Pelvis ☐R ☐L	Femur ☐R ☐L	Tibia/Shin ☐R ☐L	Foot ☐R ☐L
Arm (Humerus) ☐R ☐L	Forearm ☐R ☐L	Hand ☐R ☐L	Finger 2345 ☐R ☐L	Hip ☐R ☐L	Knee ☐R ☐L	Ankle ☐R ☐L	Toe B2345 ☐R ☐L

(CC/Location)

1) Is there a **new problem** that was not evaluated at your last visit? ☐ Y ☐ N
If so, what is it?_____

2) How long has it been since your last visit? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

♦ 3) Since your last visit, are you: ☐ Better ☐ Worse ☐ Same **(Context)**

4) Are you having **problems** with the cast or splint? If yes, describe_____

♦ 5) On a scale of 0-10 (10 is the worst), how severe is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10 **(Severity)**

♦ 6) What is the **quality** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning **(Quality)**

♦ 7) The pain is now: ☐ Constant ☐ Comes and goes (intermittent) ☐ Worse in AM ☐ Worse in PM **(Timing)**

♦ 8) Does your pain wake you from sleep? ☐ Y ☐ N **(Timing)**

♦ 9) Do you have? ☐ Swelling ☐ Numbness ☐ Cast pressure ☐ Bruising ☐ Tingling ☐ Stiffness **(Assoc Symp or Neuro ROS)**

10) What medications are you still taking for this condition? (name) ☐ Anti-inflammatory _____ ☐ Other _____ ☐ Narcotic pain killer _____ **(Mod)**

♦11) Please use check boxes below to show what treatments were done **at** or **since** your last **office** or **ER** visit.

Treatment	**Did it help?**
☐ Anti-inflammatories	☐ Y ☐ N
☐ Narcotics	☐ Y ☐ N
☐ First Cast or Splint	☐ Y ☐ N
☐ Replacement Cast or Splint	☐ Y ☐ N
☐ Physical or Occupational Therapy	☐ Y ☐ N
☐ Home exercise program	☐ Y ☐ N
☐ Surgery since last visit	☐ Y ☐ N

12) Use this area for questions you want the doctor to answer today.

_____

_____

_____

_____

INTERVAL HISTORY: ***Since your last visit:***

♦**ROS** •**Any new problems** in any of these areas? If yes, please check the boxes and explain below.
(This does not include today's bone or joint problem.)

☐ Eyes ☐ Bowels ☐ Nerves ☐ Lungs ☐ Diabetes
☐ Heart ☐ Skin ☐ Ears ☐ Urine ☐ Other bones/joints (NOT today's problem)

☐ **I have no new problems** If yes, please explain: _____

♦**PMH** •**Any new allergies?** ☐ No ☐ Yes Describe_____

•**Any new medications** prescribed by any other doctor? ☐ No ☐ Yes Describe_____

•**Have you been hospitalized** for a non-orthopaedic problem? ☐ No ☐ Yes Describe_____

♦**SH** •**Tobacco use *since your last visit:*** ☐ I still don't use tobacco ☐ I started using tobacco ☐ I still use tobacco ☐ I stopped using tobacco

•**Current Work Status?** ☐ Regular ☐ Light duty (How long?_____) ☐ Student ☐ Disabled ☐ Not working due to this problem (How long?_____) ☐ Retired ☐ Not working

Patient Signature _____ **Doctor Sig** _____

BP_____/_____Pulse_____
Temp_____Ht_____/___ ___Wt_____