Anderson Orthopaedic Clinic SINCE 1941
A Center of Excellence for Orthopaedics

SAMEER H. NAGDA, M.D./MARCELLA ROACH, PA-C
FOLLOW-UP VISIT FORM

NAME:_____ TODAY'S DATE:_____

PREFERRED EMAIL: _____

PRIMARY CARE PHYSICIAN: _____

PREFERRED PHARMACY: (Name and #): _____

CHIEF COMPLAINT: SHOULDER ELBOW KNEE ANKLE OTHER:_____
(please circle)
RIGHT LEFT BOTH

REASON FOR VISIT:_____

_____

HOW SEVERE IS YOUR PAIN (On a scale of 0-10 with 10 being the worst pain ever felt)? _____

HAS THE ISSUE BEEN (please circle one): WORSENING IMPROVING THE SAME

OTHER SYMPTOMS:_____

WHAT TREATMENTS HAVE YOU HAD SINCE YOUR LAST VISIT (circle all that apply):

NONE X-rays MRI EMG Physical Therapy Ice

Heat Medications Injections Surgery Other_____

HAVE ANY OF THESE TREATMENTS HELPED: YES NO

IF SO WHICH TREATMENT: _____

HAVE YOU RECENTLY EXPERIENCED ANY OF THESE SYMPTOMS: YES_____(circle all that apply):

NUMBNESS / TINGLING CHEST PAIN STOMACH PAIN NONE

SINCE YOUR LAST VISIT ON _____HAS THERE BEEN ANY CHANGE(S) IN YOUR MEDICAL HISTORY?

NONE _____ YES_____ IF YES, PLEASE EXPLAIN: _____

_____

Patient Signature:_____ Date:_____
(Or the person who is filling out this form)

Below for office use only:

Height: _____ Weight: _____ R:_____

PE:

Assessment:

Signed:_____

Plan:

Reviewed:_____