Dr. Ahmed S. Bata
Orthopedic Surgeon
Nile Orthopedic and Rehabilitation Association, Inc
25805 Barton Rd, STE A106, Loma Linda CA 92354
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Follow-up Patient Questionnaire

PERSONAL INFORMATION

Name: _____ Sex: ☐ M ☐ F DOB: _____ Age_____
Address: _____
City, State, Zip _____
Phone Numbers: home _____work _____other_____
Insurance: company_____ ID#_____ ph#_____
Email: _____ Pharmacy: _____

Please if you are here for a new problem ask for the new patient form

ORTHOPAEDIC PROBLEM PROGRESS

(You may check more than one answer for the same question)

Purpose of visit (what hurts)? ☐ Ankle ☐ Foot ☐ Heel ☐ Other?

_____
_____

which side? ☐ Left ☐ Right ☐ Both

How do you feel your problem is progressing?

☐ Improving ☐ Worsening ☐ No Change ☐ Other?

_____
_____

What treatment have you had?

☐ cast/splint ☐ Brace_____ ☐ Injection ☐ Physical Therapy
☐ Orthopedic shoes ☐ Orthotics
☐ Surgery_____
☐ X-ray ☐ CT Scan
☐ MRI ( )Within 6 months ( )More than 6 months

☐ Medicine/Pain medicine _____

☐ Antibiotics_____

Other (please Explain):

_____
_____
_____

Physician Recommendations:

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What is your Weightbearing Status:
☐ Full Weight bearing ☐ Non Weightbearing ☐ Partial Weightbearing
☐ Weightbearing as tolerated

Rate your pain: (from 0-10 if 0 in no pain and 10 is the worst pain imaginable)

_____
_____

Frequency of pain: ☐ Constant ☐ Every _____(mins/hour/day/week/month/year)
Duration of pain: _____ (mins/hour/day/week/month/year)
Change over time: ☐ getting better ☐ getting worse ☐ fluctuates ☐ plateaued

_____
_____

What makes symptoms better?

_____
_____

What makes symptoms worse?

_____
_____

What Medication do you take?

Medication	dose	frequency	Medication	dose	frequency

Did you have any change in any of the following since last visit?

1) **Medical History:**

_____
_____

2) **Surgical History**:

_____
_____

3) **Allergies History**:

_____
_____

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4) Social History:

_____
_____

5) Any significant change in your health:

_____
_____

Females: Are you pregnant? ☐Yes ☐No (Please let us know if there is any probability you may be pregnant. Xrays may harm your baby)

Is there anything else you would like us to know?

_____
_____
_____
_____
_____
_____

Signature of Patient/ Legal Guardian: **Date:**

_____ _____

If Legal Guardian,
Name: _____ Relation: _____

Signature of Dr. A Bata: _____

By signing above, I (Dr. Bata) acknowledge that I have reviewed this form and discussed the relevant medical concerns with the patient. This form is part of the patient's medical records.