Gavin Orthopaedics, LLC

MOSS CREEK ORTHOPAEDIC URGENT CARE
Scrapes • Sprains • Shots • Stitches

Follow-Up Visit

Patient Name: _____ Date: _____

Date of Birth _____ Age:_____

Body area you are being seen for today:_____

Problem is presently: ☐ No Pain ☐ Unchanged ☐ Improving ☐ Worsening

Please rate your pain: ☐ 1 (No pain), ☐ 2, ☐ 3, ☐ 4, ☐ 5, ☐ 6, ☐ 7, ☐ 8, ☐ 9 and ☐ 10 (severe pain)

The pain is: ☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull

Other Complaints: ☐ Giving Way ☐ Locking ☐ Night Pain ☐ Numbness/ Tingling

Activities interfered with include:

☐ Sports ☐ Walking ☐ Shopping ☐ Stair Climbing ☐ Waking or Sleeping
☐ Running ☐ Gardening ☐ Working ☐ Kneeling ☐ Squatting ☐ Rising from a chair
☐ Other_____

Treatments that have been tried include:

Treatment	Helped	Did Not Help (Unchanged)
☐ Anti Inflammatory	_____	_____
☐ Pain Medications	_____	_____
☐ Exercises	_____	_____
☐ Reduced Activity	_____	_____
☐ Physical Therapy	_____	_____
☐ Bracing /Splint	_____	_____
☐ Crutches/Cane	_____	_____
☐ Walker	_____	_____
☐ Injection	_____	_____

Review of Systems: Any Changes since the last visit with the following: Check & Explain

☐ Weight Loss	☐ Mouth/Throat	☐ Kidneys/Bladder
☐ Fevers	☐ Heart	☐ Skin
☐ Eyes	☐ Lungs	☐ Nerves/Aniety/Depression
☐ Ears	☐ Stomach	☐ Bleeding/Clotting
☐ Nose	☐ Bowels	☐ Recurrent Infections

Explain: _____

New Medication?: _____

Recent Surgery?:_____

Any Questions for Dr. Gavin that you would like answered?: _____

Please Circle/Check your responses and fill this form out completely. Thank you.

Patient Signature: _____

Physician Signature: _____