CHART #: _____

Capital Area Orthopedic Associates LLC

HPI – Follow Up

PATIENT NAME: _____ DOB: _____-_____-_____
LAST FIRST MI

DATE OF APPOINTMENT: _____

HISTORY OF PRESENT ILLNESS (HPI)

Chief Complaint (In your own words) Why are you here today? _____

_____

Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly

Are you experiencing pain at this time? ☐ Yes ☐ No

Since your last visit has your pain: ☐ Resolved ☐ Improved ☐ No Change ☐ Worse

Does your problem awaken you from sleep? ☐ Yes ☐ No

Current Work Status: ☐ Regular Duty ☐ Light Duty ☐ Unable to Work

LOCATION

What problem is being addressed at your appointment? _____

_____

QUALITY

How would you describe the problem/pain today?

☐ Aching ☐ Burning ☐ Cold ☐ Cramping ☐ Crushing ☐ Heaviness

☐ Hot ☐ Nagging ☐ Pressure ☐ Sharp ☐ Shock Like ☐ Shooting

☐ Sore ☐ Stabbing ☐ Stinging ☐ Throbbing ☐ Tightness ☐ Pins & Needles

If your pain is radiating, how would you describe the pain?

☐ Numbness and tingling ☐ Numbness only ☐ Tingling only

SEVERITY

On a scale from 1 to 10, how severe is the pain today?

(1 – Barely Feel It, 10 – Most Severe Pain Imaginable): _____

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DURATION

Date of Injury: (Review previous note)

TIMING

How would you describe the duration of your problem/pain today?

☐ Constant ☐ Comes and Goes ☐ Only w/ movement ☐ Pain has Resolved

CONTEXT

Where were you when the injury first occurred? (Review previous note)

MODIFYING FACTORS

What has helped your pain since your last visit?

☐ Rest ☐ Ice ☐ Heat ☐ Medication ☐ Nothing ☐ Other

What medications are you currently taking for pain?

☐ No Medications ☐ Vicodin or Tylenol 3 ☐ Percocet ☐ Tylenol

☐ Ibuprofen (Advil/Motrin) ☐ Aleve/ Naprosyn ☐ Other

AGGRAVTING FACTORS

What seems to aggravate the pain today?

☐ Exercise ☐ Sitting ☐ Standing ☐ Walking ☐ Repetitive Motions

☐ Overhead activities ☐ Coughing, Sneezing, Straining ☐ Rest ☐ Bending ☐ Stair Climbing

☐ Nothing ☐ Other

ASSOCIATED SIGNS &SYMPTOMS

What symptoms have you developed as a result of the problem/injury since your last visit?

☐ Fever ☐ Drainage ☐ Nausea ☐ Bleeding ☐Headache

☐ Numbness/Tingling ☐ Pain ☐ Weakness ☐ Joint Problems ☐ Other: _____

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TESTS & TREATMENTS

What tests have you had done since your last visit, if any?

	When	Where
☐ MRI		
☐ X-Rays		
☐ CT Scan		
☐ EMG		
☐ Ultrasound		
☐ Other		

What treatments have you had since your last visit? ☐ None

☐ Over the Counter Medications ☐ Heat

☐ Prescription Medication ☐ Home Exercise

☐ Brace, Cast, Splint or Sling ☐ Injection Therapy

☐ Surgery ☐ Physical Therapy

☐ Acupuncture ☐ ER Visit

☐ Massage Therapy ☐ Previous Physician visit

☐ Chiropractic Therapy ☐ Previous Surgery

☐ Ice ☐ Pain Management

☐ Elevation ☐ Other

How have these treatments impacted your problem?

☐ Resolved ☐ Improved ☐ No Change ☐ Worse