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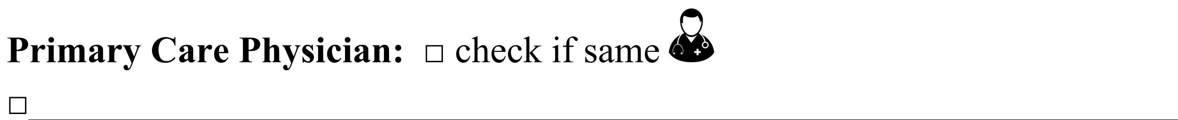
Follow-Up Office Visit Questionnaire (since Last visit)

General Info:

Did you fill out this form on our Patient Portal at drshehadi.com? □ Y □ **N**
If not, please fill out this paper form.

Name: ____ **Date**: ____________
Age:__________
Best Phone Number: □ same # *or* □ (_____) ____-________
Email Address: □ same *or* □______________________
Did your weight change? □ Y □ **N** **Estimated Weight (today)**: _______lbs

Pharmacy Preference: □ check if same
□____



Primary Care Physician: □ check if same
□____

Medical Insurance: □ check if same
□____

Chief Complaint (Why you are here TODAY)

____

1. **Have your symptoms changed since your last office visit?** □ Better □ Worse □ Same

2. **Describe Any New Treatment(s)** since your last visit (such as physical therapy, braces, injections, etc.): ___________________________

Physical Therapy □ Y □ N Did it help any? □ Y □ N
Date(s) completed ____________________

Bracing □ Y □ N Did it help any? □ Y□ N

Injections □ Y □ N Did it help any? □ Y □ N
Date(s) completed __________________

Regenerative Medicine: Have you received any treatments such as stem cells, PRP, or exosomes?
□ Y □ N _______________________________

3. **Any New Imaging**, such as CT, MRI or X-rays? □ Y □ N

If so What, When and where? ____

Did you bring the CD disc? □ Y □ N

4. **Rate your pain on average** *(0 is no pain, 10 is worst pain)*: 0-10 _________

Pain at best (0-10) __________ **Pain at worst** (0-10) __________

5. **What makes the pain better?**

____

6. **What makes the pain worse?**

____

7. **Do you have numbness?** □ Y □ N **Where?** __________________

8. **Burning?** □ Y □ N **Where?** __________________________

9. **VERY IMPORTANT QUESTIONS:**
Urine incontinence? □ Y □ N **Bowel incontinence?** □ Y □ N

10. Are you on **any NEW** medications or have you **stopped** any medications since last seen here? □ Y □ N

11. Have you developed any **NEW** medication ***Allergies?*** □ Y □ **N**
Which ones____

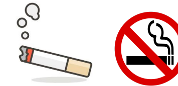
****

<u>Review of Symptoms (ROS)</u>:

12. Have you had any of the following since last visit? *(mark all that apply)*

Related to Spine issues:	**Related to Brain issues:**
❑ Fever	❑ Headaches
❑ Unintentional weight loss	❑ Problems with your memory
❑ Excessive fatigue	❑ Disorientation
❑ Neck pain	❑ Difficulty with speech
❑ Back pain	❑ Inability to concentrate
❑ Joint pain, swelling, or stiffness	❑ Loss of appetite
❑ Muscle cramps/spasms	❑ Double or blurred vision
❑ Insomnia	❑ Face weakness
❑ Arm or leg weakness	❑ Fainting
❑ Arm or leg pain	❑ Dizziness/lightheadedness
	❑ Seizures

13. Please list any changes to your **Medical/surgical or social history** (such as a change in

smoking status): ____ 

Do you currently smoke? □ Y □ **N**   Are you trying to quit?   □ Y □ **N**

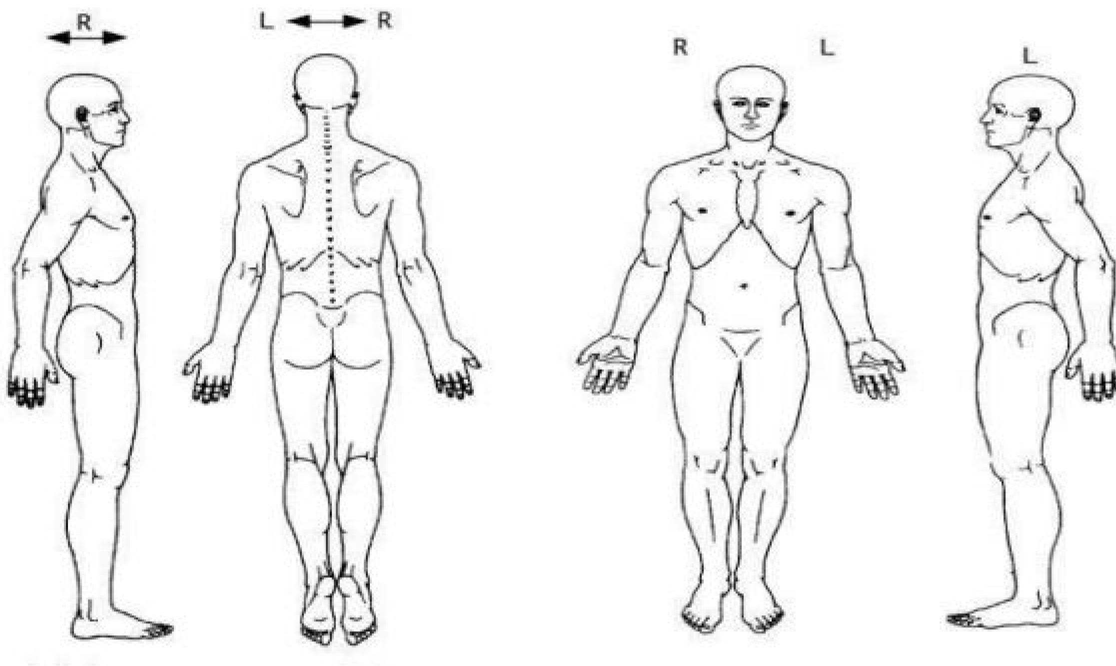
14. Have you visited our **website DrShehadi.com** since your last visit? □ Y □ N

Have you seen our **Patient Resources** Section on our website?   □ Y □ N

Do you use our Patient Web Portal?

□ Y □ N

15. Please **SHADE** in area(s) where your **PAIN is located and X where the NUMBNESS** is located:



Patient Signature: ______________________________ **Date**______________