Tufts Medical Center

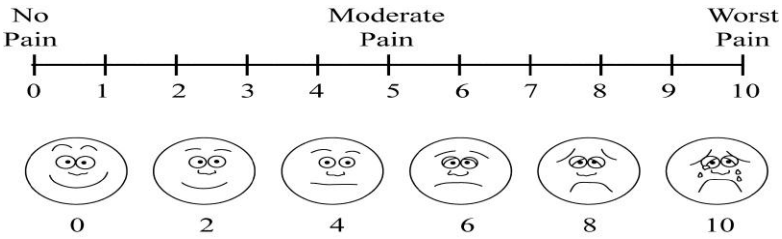
Department of Orthopaedics
Follow-Up Evaluation Form

PLACE LABEL HERE

Please describe the reason for your visit: ☐ Left ☐ Right

_____

Please rate your pain:



Allergies: _____

Do you currently smoke? Y / N If yes, how much? _____

Have you ever smoked? _____

Medication List: Please provide all of your current medications

Medication	Dose	Times/Day

Review of Systems: Please circle any of the following that apply to you

Eyes (loss of vision)	Numbness/Tingling	Dental Problems
Ear, Nose, Throat	Anxiety/Depression	Joint/Muscle Pains/Cramps
Digestion, Stomach Bowel	Fever/Chills/Fatigue	Blackout/Fainting
Bladder Problems	Chest Pain/Tightness	
Bleeding Problems	Skin Rash	

Please explain circled answers:

_____

_____