JOHNS HOPKINS
MEDICINE

Welcome

Patient's ID sticker will go here

RETURN PATIENT INFORMATION
For Dr. McFarland's Patients

INSTRUCTIONS: *Please fill this out in its entirety.*

Name: _____ Date: _____

I. NEW PROBLEM ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both

II. JOINT OR PART(S) THAT ARE BOTHERING YOU *(List)* _____

III. HAVE YOU HAD SURGERY? ☐ Yes ☐ No Date _____

IV. SINCE YOU WERE LAST SEEN:

1. How is your pain? ☐ Improved ☐ Unchanged ☐ Worse
2. Does your pain wake you at night? ☐ Yes ☐ No
3. How is motion of your joint? ☐ Better ☐ Unchanged ☐ Worse
4. Did you return to work? ☐ Yes ☐ No ☐ Never Stopped
5. Did you return to your sport? ☐ Yes ☐ No
6. Have you had physical therapy? ☐ Yes ☐ No
7. Did you take the medicine prescribed at last visit or on your own? ☐ Yes ☐ No
   - A. Anti-Inflammatory Agent ☐ Yes ☐ No Please give name _____
   - B. Pain Medication Agent ☐ Yes ☐ No Please give name _____
   - C. Tylenol ☐ Yes ☐ No
     How many pills? _____ How often? _____
   - D. Medrol Dose Pack ☐ Yes ☐ No
     If yes: ☐ One Pack or ☐ Two Pack
8. Have you been putting ice on the area? ☐ Yes ☐ No
   How often? _____ ☐ Per Day _____ ☐ Per Week
9. Did you have other tests? ☐ Yes ☐ No
   ☐ MRI ☐ Nerve Studies (EMG/NCS ☐ Bone Scan ☐ CAT Scan ☐ Other _____

V. SINCE YOUR LAST VISIT:

1. Have you had any surgery? ☐ Yes ☐ No
   If yes, please describe even if it was not to your extremities _____
   _____
2. Have you had any new problems with:
   - A. Tingling or Numbness in Arms or Legs ☐ Yes ☐ No
   - B. Trouble with other Joints ☐ Yes ☐ No
   - C. Trouble with your Heart ☐ Yes ☐ No
   - D. Trouble with your Breathing ☐ Yes ☐ No
   - E. Trouble with your Bowels ☐ Yes ☐ No
   - F. Trouble with your Bladder ☐ Yes ☐ No
   - G. Trouble with your Skin ☐ Yes ☐ No
   - H. Trouble with your Hearing ☐ Yes ☐ No
   - I. Trouble with your Eyes ☐ Yes ☐ No
   - J. Trouble with your Speech ☐ Yes ☐ No
3. Have you started any new medications? ☐ Yes ☐ No
   If yes, please list medications: _____
4. Have you had any fevers / chills? ☐ Yes ☐ No
5. Have you had any shortness of breath or chest pains? ☐ Yes ☐ No
6. Have you had any drainage from any wounds? ☐ Yes ☐ No

Is there anything new about your condition you would like to add? _____

This questionnaire has been reviewed with the patient.

_____ _____

Physician / Resident / PA or Nurse's Signature Date

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Patient Name:_____ Date: _____

CONSTITUTION

NAD ☐ Yes ☐ No **ORIENTEDx3** ☐ Yes ☐ No **Mood** ☐ Calm ☐ Agitated

BP _____ **T** _____ **WT** _____

PERIPHERAL EDEMA ☐ Yes ☐ No

LYMPH NODE SWELLING ☐ Yes ☐ No

CERVICAL SPINE ☐ Normal ☐ Abnormal

LUMBAR SPINE ☐ Normal ☐ Abnormal

HEAD/NECK PALPABLE MASS Yes___ No___

ROM ☐ Normal ☐ Abnormal

ROM ☐ Normal ☐ Abnormal

UPPER EXTREMITIES		
	Right	**Left**
Atrophy		
Winging		
Scapular Dyskinesis		
ROM Active / Passive		
Flexion		
Abduction		
90 Degrees		
ER		
IR		
ER Side		
IR Up Back		
Shrug Sign		
Drop Arm Test		
Painful Arc		
Neer		
Hawkins		
ERLS		
Superior Subluxation		
Whipple Test		
Speed's Test		
Active Comp.		
Dynamic Shear		
Adduction Stress		
One Finger Test		
Lift Off		
Lift Off Lag		
Pain Resisted Lift off		
Belly Press test		
Bear Hug test		
Apprehension		
Laxity anterior		
Sulcus		
Laxity Anterior I, II, III		
Posterior I, II, III		
Crank test		
Relocation Test		
Tenderness (Sites)		

LOWER EXTREMITIES		
	Right	**Left**
Atrophy		
Deformity		
Reflexes		
KJ		
AJ		
Babinski		
Sensation		
L3		
L4		
L5		
S1		
Strength		
Abd		
Quads		
Hamstrings		
Dorsiflexors		
Plantarflexors		
Invertors		
Evertors		
Lachman's		
MCL		
LCL		
Post Drawer		
ROM Flex		
Extend		
Pulses		
UPPER EXTREMITIES CONTINUED		
Sensation		
Skin		
Vascular		
Strength-Ab		
Pect		
Biceps		
Triceps		
Intrinsics		
Abpollbrevis		
Ext. Rotation		
Reflex-Biceps		
Triceps		
BR		
Hoffman's Test		