PHYSICIANS' CLINIC
of Iowa, P.C.

ORTHOPAEDIC
TRAUMA/PEDIATRICS FOLLOW UP

Today's Date _____ Phone Number _____

First Name _____ Last Name _____ Date of Birth _____

Relationship to Patient _____ Referring Provider _____

What has been your treatment thus far? _____

_____

_____

_____

Did you have surgery? ☐ Yes ☐ No If yes, what surgery? _____

Date of surgery _____

Any problems or concerns you have with your treatment? _____

_____

Have you been to the ER for the current problem? ☐ Yes ☐ No Date and location of ER visit _____

If yes, what was the treatment in the ER? _____

_____

Please tell us your expectation for this visit _____

_____

_____

Do you need any of the following forms completed? ☐ School ☐ Work ☐ Physical Education ☐ Handicap Plaque ☐ Disability

Do you need any medication refills? ☐ Yes ☐ No If so, _____

_____ _____

Patient Signature Date