HA Injection Questionnaire

Please complete all information below.

ORTHOWASHINGTON

Patient Information

Patient Name: _____ Date of Birth: _____

Doctor's Name: _____ Appointment Date: _____

Injection Site:

☐ Left Knee ☐ Right Knee ☐ Both Knees

Please answer all of the following:

1. What number injection are you here for? ☐ First ☐ Second ☐ Third
2. Since your last visit, how are you feeling? ☐ Better ☐ Worse ☐ Same ☐ Too early to tell
3. On a scale of 0 to 100%, how much better are you than the last visit? (0% = no better): % _____
4. On a scale of 0 to 10 (10 is worst), what is the severity of your pain? (circle one):

   0 1 2 3 4 5 6 7 8 9 10
5. Are you having any side effects from the HA injection(s)? ☐ Yes ☐ No

   If Yes, please explain: _____

Patient Signature: _____ Date: _____

MD/PA-C Signature: _____ Date: _____

FOR OFFICE USE ONLY – Do not write below this line.

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