Post-Operation Questionnaire

Please complete all information below.

ORTHOWASHINGTON

Patient Information

Patient Name: _____ Date of Birth: _____

Doctor's Name: _____ Today's Date: _____

What body part(s) is this visit regarding?

SHOULDER: ☐ Left ☐ Right **ELBOW:** ☐ Left ☐ Right **WRIST:** ☐ Left ☐ Right

HAND: ☐ Left ☐ Right **HIP:** ☐ Left ☐ Right **KNEE:** ☐ Left ☐ Right

ANKLE: ☐ Left ☐ Right **FOOT:** ☐ Left ☐ Right OTHER: _____

Please answer all of the following:

1. Since your last visit, how are you feeling? ☐ Better ☐ Worse ☐ Same ☐ Too early to tell
2. On a scale of 0 to 100%, how much better are you than the last visit? (0% = no better): % _____
3. 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
4. Are you having any of the following complications since surgery?
   a. Unmanageable Pain ☐ Yes ☐ No
   b. Excessive Swelling ☐ Yes ☐ No
   c. Excessive Draining ☐ Yes ☐ No
   d. Redness ☐ Yes ☐ No
   e. Calf Pain ☐ Yes ☐ No
   f. Other: _____
5. Are you taking any of the following pain medications?
   a. Hydrocodone-Acetaminophen / Norco / Vicodin ☐ Yes ☐ No
   b. Oxycodone ☐ Yes ☐ No
   c. Tylenol ☐ Yes ☐ No
   d. Ibuprofen / Advil ☐ Yes ☐ No
   e. Aleve ☐ Yes ☐ No
   f. MS Contin (long acting) ☐ Yes ☐ No
   g. Other: _____
6. Are you doing any of the following?
   a. Home Exercises ☐ Yes ☐ No
   b. Physical Therapy (if Yes, how many times per week: _____) ☐ Yes ☐ No
   c. Ice ☐ Yes ☐ No
   d. Heat ☐ Yes ☐ No
   e. Elevation ☐ Yes ☐ No
   f. Rest ☐ Yes ☐ No
   g. Brace ☐ Yes ☐ No
   h. Assistive Devices (e.g. crutches, walker, scooter, wheelchair) ☐ Yes ☐ No
7. What is your work status?
   ☐ Not working due to condition ☐ Full Duty ☐ Light Duty ☐ Retired ☐ Other: _____

Patient Signature: _____ Date: _____

MD/PA-C Signature: _____ Date: _____

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

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