HA Injection Questionnaire Please complete all information below.



| Patient Information | | | | | | | | | |
|---|----------------------|-------------------|-----------|--------|--------|-------|-------|------|----|
| Patient Name: | | Date | of Birth | า: | | | | | |
| 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 fo | or? First | Seco | ond 🔲 | Third | | | | | |
| 2. Since your last visit, how are you feeling | ig? Bette | er Wors | se 🗌 | Same | П Т | oo ea | ly to | tell | |
| 3. On a scale of 0 to 100%, how much be | etter are you thar | n the last visi | t? (0% = | = no b | etter) |): % | | | |
| 4. On a scale of 0 to 10 (10 is worst), wha | it is the severity o | 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 | ne HA injection(s | s)? Yes | | No | | | | | |
| If Yes, please explain: | | | | | | | | | |
| | | | | | | | | | |
| Patient Signature: | | | Date: | | | | | | |
| MD/PA-C Signature: | | | Date: | | | | | | |
| | | | | | | | | | |
| FOR OFFICE USE ONLY – Do not write be | ow this line. | | | | | | | | |
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