## **Post-Operation Questionnaire**

Please complete all information below.



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	<b>WRIST</b> : ☐ Left	Right
HAND: Left Right	HIP: Left Right	KNEE: Left	Right
ANKLE: Left Right	FOOT: Left Right	OTHER:	
Please answer all of the following:			
Since your last visit, how are you feeling	g? Better	Worse Same	Too early to tell
2. On a scale of 0 to 100%, how much be	<del></del>	<u> </u>	
3. On a scale of 0 to 10 (10 is worst), wha			5 6 7 8 9 10
4. Are you having any of the following co			
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 pai			
a. Hydrocodone-Acetaminoph	en / 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, ho	w many times per week:	∐ Yes	∐ No
c. Ice d. Heat		∐ Yes	∐ No □ No
e. Elevation		∐ Yes ∏ Yes	□No
f. Rest		☐ Yes	□No
g. Brace		☐ Yes	□ No
9	hes, walker, scooter, wheelchair)	☐ Yes	□No
7. What is your work status?	nes, warker, scooter, wheelenan		
Not working due to condition	Full Duty Light Duty Retired	I Other:	
Patient Signature:		Date:	
MD/PA-C Signature:		Date:	
FOR OFFICE USE ONLY – Do not write	below this line.		