

Pre-Exam Questionnaire - POST-SURGERY

1. On what part of the body did you receive surgery? _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
2. When was the surgery? ____/____/20____
3. Why did you need surgery?
4. List the dates and results of any: <input type="checkbox"/> X-Rays: <input type="checkbox"/> MRIs: <input type="checkbox"/> Other Tests:
5. What type of problems are you experiencing now?
7. My pain/problem is slowly getting: <input type="checkbox"/> worse <input type="checkbox"/> better <input type="checkbox"/> staying the same
8. My pain/problem bothers me: <input type="checkbox"/> constantly <input type="checkbox"/> most of the time <input type="checkbox"/> only occasionally <input type="checkbox"/> once in awhile
9. On a scale from 0 to 10, what is the worst your pain/problem has been in the past several days? ____/10 <div style="display: flex; justify-content: space-between; font-size: small; margin-bottom: 5px;"> <i>Mild discomfort</i> <i>Moderate</i> <i>Unbearable, Severe</i> </div> 0 1 2 3 4 5 6 7 8 9 10
10. Do you have any regular numbness or tingling? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. What seems to make your pain/problem worse?
12. What makes your pain/problem feel better?
13. List how your usual everyday activities are affected:
14. List any medications you are currently taking:
15. List all past surgeries with dates:
16. Do you have, or have you had any of the following? <input type="checkbox"/> Diabetes <input type="checkbox"/> Pacemaker <input type="checkbox"/> Cancer <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Hernia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Fractures <input type="checkbox"/> Current Pregnancy <input type="checkbox"/> Heart Disease <input type="checkbox"/> Metal Implants <input type="checkbox"/> Bowel Abnormalities <input type="checkbox"/> Asthma <input type="checkbox"/> Neuropathy <input type="checkbox"/> Heart Attack <input type="checkbox"/> Headaches <input type="checkbox"/> Urine Leakage <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> _____ <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Dizziness / Fainting <input type="checkbox"/> Urine Retention <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> _____ <input type="checkbox"/> Angina <input type="checkbox"/> Anxiety <input type="checkbox"/> COPD <input type="checkbox"/> Degenerative Disc <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Sleep Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Allergies: _____

Patient Name

Signature

____/____/20____
Today's Date