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Hospital for Special Surgery
1 Blachley Rd~Stamford, CT 06902

HOSPITAL FOR **SPECIAL SURGERY**

PATIENT QUESTIONNAIRE (FOR FOLLOW-UP VISITS)

Patient Name: ______ DOB: ______ Date: ______

Please take a moment to answer the following questions in reference to your current pain level and any changes. You will have to fill this form out before **EVERY** follow up visit.

The doctor may have someone shadowing her for educational purposes; do you consent to their presence during your office visit today?* ***YES* *or* ***NO***

1. What is your pain score today using a scale of 1 to 10, with 10 being the most painful?

2. Has your pain changed? If so please explain. For example medication, acupuncture, stress, new injury, weather etc.

3. Have you experienced any changes in your limitations? For example walking better or worse, working, house work, stairs etc.

4. Are there any specific changes you want to make to your current treatment routine?

5. **IF MEDICARE IS YOUR PRIMARY INSURANCE PLEASE ANSWER THE FOLLOWING QUESTIONS:**
    a. Have you fallen in the past year? Yes or No
        i. If Yes, how many falls? 1 or 2+
        ii. Were there any injuries? Yes or No

Office Use:

Initials: ___________ BP: ___________ Pulse:___________
Drug/Dosage: ___________________ Timing 1st 2nd 3rd Lot#:___________________