Pre-Exam Questionnaire - POST-SURGERY

1. On what part of the body did you receive surgery? _____ ☐ Right ☐ Left ☐ Both

2. When was the surgery? ____/____/20____

3. Why did you need surgery?

4. List the dates and results of any: ☐ X-Rays: ☐ MRIs: ☐ Other Tests:

5. What type of problems are you experiencing now?

7. My pain/problem is slowly getting: ☐ worse ☐ better ☐ staying the same

8. My pain/problem bothers me: ☐ constantly ☐ most of the time ☐ only occasionally ☐ 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

Mild discomfort *Moderate* *Unbearable, Severe*

0 . . . . . 1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 10

10. Do you have any regular numbness or tingling? ☐ Yes ☐ 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?

☐ Diabetes	☐ Pacemaker	☐ Cancer	☐ Seizures	☐ Stroke/CVA
☐ High Blood Pressure	☐ Hernia	☐ Osteoporosis	☐ Fractures	☐ Current Pregnancy
☐ Heart Disease	☐ Metal Implants	☐ Bowel Abnormalities	☐ Asthma	☐ Neuropathy
☐ Heart Attack	☐ Headaches	☐ Urine Leakage	☐ Rheumatoid Arthritis	☐ _____
☐ Heart Palpitations	☐ Dizziness / Fainting	☐ Urine Retention	☐ Osteoarthritis	☐ _____
☐ Angina	☐ Anxiety	☐ COPD	☐ Degenerative Disc	☐ Allergies:_____
☐ Congestive Heart Failure	☐ Sleep Disorder	☐ Depression	☐ Spinal Stenosis	☐ Allergies:_____

_____ _____ ___/___/20___

Patient Name Signature Today's Date

Reviewed By:____