NEW ORTHOPAEDIC ISSUE EVALUATION

Name: ____ **Date:** _________________________

What hurts you? ____ **RIGHT or LEFT?**

How long has this hurt you?_______________________

Is your pain getting WORSE / NO CHANGE / BETTER ?

What is your pain level? 1 2 3 4 5 6 7 8 9 10

How would you describe your pain? Aching / Deep / Throbbing / Sharp / Comes and goes / 24 – 7 / Numbness and tingling / Burning

What happened? _______________________ ____

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What medications are you taking for this problem?

Tylenol (acetaminophen)	Celebrex (celecoxib)	Nabumetone (Relafen)	Meloxicam (Mobic)	Diflunisal (dolobid)
Ibuprofen (advil, motrin)	Indomethacin (Indocin)	Oxaprozin (Daypro)	Salsalate	Ketoprofen (orudis)
Diclofenac sodium (cataflam)	Voltaren, Arthrotec)	Naproxen (Naprosyn)	Sulindac (clinoril)	Piroxicam (Feldene)
Etodolac (lodine)	NARCOTICS			

Have you had injections of steroid (cortisone)? Yes / No How many?___________ Did it help? Yes / No

Have you had gel injections (synvisc, Rooster comb)? Yes / No How many?___________ Did it help? Yes / No

Have you had physical therapy? Yes / No Where?____________________ Did it help? Yes / **No**

Does your pain…

Limit your daily activities? Yes / No Affect your lifestyle? Yes / No

Disturb your sleep? Yes / No Prevent you from exercising? Yes / No

Affect your ability to work? Yes / No Have you tried to lose weight? Yes / No

Difficulty with stairs? Yes / No Make walking painful? Yes / No

Have you had surgery for this problem? Yes or No.

Percent Improvement Since Surgery:

0 10 20 30 40 50 60 70 80 90 100

Are You Glad You Had The Surgery? Yes / No

If no, why not?____

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