

## Post-Op & Injection Intake Form

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name                      First Name                      Appointment Date                      What Dr. are you seeing today?

Please fill out this Section if you are here for a POST-OP appointment

CC: Chief complaint: What is the reason for this visit? \_\_\_\_\_

What was your Surgery Date? \_\_\_\_\_

What type of pain do you have?     Burning     Diffuse     Dull/Aching     Localized     Radiating     Sharp  
 Shooting     Stabbing     Throbbing     Tightness     Tingling

Please Check off if you have any of the following:     None

Fever                       Chills                       Drainage at wound                       Swelling

What is your level of pain today?    Please Circle    0    1    2    3    4    5    6    7    8    9    10    most severe

Please fill out this Section if you are having Injection 2-5 today

Have you ever had an Injection?     Y     N

If yes, what was the date of your last Injection? \_\_\_\_\_ What injection was it?    1    2    3    4    5

In the last year what type of injections have you had? Supartz    Synvisc    Orthovisc    Other \_\_\_\_\_

Did you ever have any reaction to the Injection/s?     Y     N

If you had an Injection, did it help you with your Pain?     Y     N

What percentage did it help?    Please circle    0    10    20    30    40    50    60    70    80    90    100%

Please fill out this Section if you are here for a FRACTURE CARE appointment today

Have you had increased     Pain     Swelling    What is your level of pain today? From 0 to 10 \_\_\_\_\_

Do you need your cast replaced today?     Y     N

Are you currently on pain medications for this injury?     Y     N    If yes, which one/s \_\_\_\_\_