Orthopaedic Specialists of North Carolina
Pain Follow Up Questionnaire

Please complete this form before seeing Dr. Watson. Your answers will help us understand your progress and help us alter your treatment plan appropriately.

Name:______________________________ (First / MI / Last) Date:______________ Age:__________

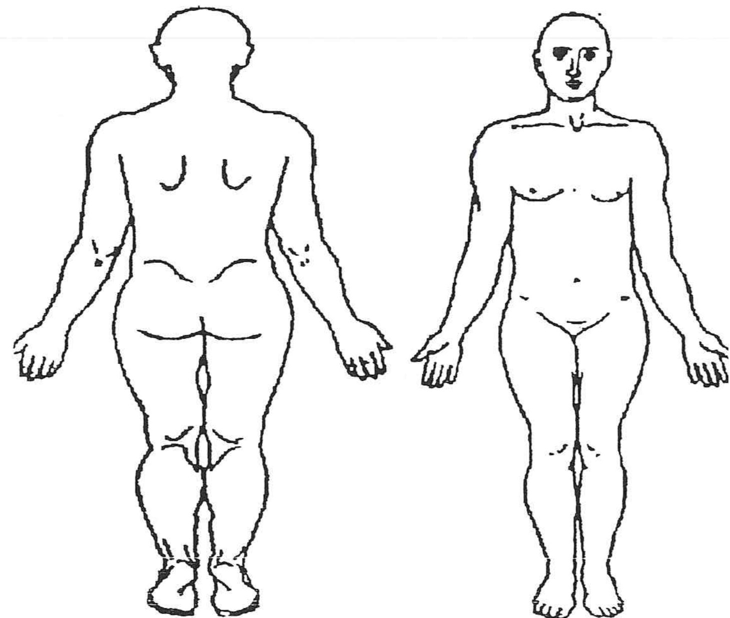
Family Physician:______________________ Referring Physician:______________________

Please tick any of the words that describes your pain under the column that describes it's intensity.

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

PLEASE DRAW YOUR PAIN

xxx	Burning	==	Numbness
!!	Stabbing	**	Cramping
00	Aching	##	Other



Rate your pain: (Tick along the scales below)

Today – No Pain [________________________] Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

On Most Days – No Pain [________________________] Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

At It's Worst – No Pain [________________________] Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

At It's Best – No Pain [________________________] Worst Possible Pain
0 1 2 3 4 5 6 7 8 9 10

When is your pain the worst? (Please check one)

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Night
- ☐ No regular pattern

Functional History:

Please rate the effect your pain has on the activities listed below by marking on each line:

General activities of living:

No Effect [____] Completely Interferes

0 1 2 3 4 5 6 7 8 9 10

Your Mood:

No Effect [____] Completely Interferes

0 1 2 3 4 5 6 7 8 9 10

Ability to walk:

No Effect [____] Completely Interferes

0 1 2 3 4 5 6 7 8 9 10

Ability to Work: *(including both inside and outside the home)*

No Effect [____] Completely Interferes

0 1 2 3 4 5 6 7 8 9 10

Relationships with other people:

No Effect [____] Completely Interferes

0 1 2 3 4 5 6 7 8 9 10

Sleep:

No Effect [____] Completely Interferes

0 1 2 3 4 5 6 7 8 9 10

Enjoyment of Life:

No Effect [____] Completely Interferes

0 1 2 3 4 5 6 7 8 9 10

Review of Systems:

Please circle any complaints you currently have below:

General
Fatigue
Fever
Night sweats
Unplanned Weight loss

Eyes and ENT
Blurry vision
Ringing in the ears
Seasonal Allergies
Sore throat

Cardiovascular/Heart
Chest pain/pressure
Irregular heart beat
Swelling in feet

Respiratory/Lung
Shortness of breath
Wheezing
Cough

Gastrointestinal
Diarrhea
Loss of stool
Heartburn

Musculoskeletal
Muscle aches
Back pain
Joint pain/stiffness
Muscle weakness

Mental Health
Anxiety or Panic
Depressed mood
Difficulty concentrating
Feeling of hopelessness

Neurological
Numbness / Tingling
Seizures
Frequent falls
Poor balance

Skin
Rash
Sores / Ulcers

Urinary system
Frequent urination
Urgency to urinate
Urinary hesitancy
Urinary incontinence

Hematologic
Easy bleeding / bruising

Do you suffer from constipation? Yes / No

If YES - What do you currently take for constipation? ______________________________