Orthopaedic & Spine Surgery Institute
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POST-OP FORM

Last Name: _____ **First Name:** _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Height:** _____ **Weight:** _____ **Sex:** ☐ Male ☐ Female

Preferred Name: _____ **Preferred Pharmacy (Name & Location):** _____

Are you currently residing in a nursing facility? ☐ No ☐ Yes **Name/ Address of facility?** _____

Has your insurance changed since your last visit? ☐ No ☐ Yes, please provide the updated card(s) to the front desk staff.

HISTORY OF PRESENT INJURY/ COMPLAINT

Date of Surgery: _____

Check all that apply to the surgical incision. ☐ No Concern ☐ Redness ☐ Drainage ☐ Swelling ☐ Other: _____

How is your pain from before your surgery? ☐ Improving ☐ Unchanged ☐ Worsening

How often do you experience this pain? ☐ Constantly ☐ Intermittently ☐ Episodic (occurs irregularly)

Please describe your pain: ☐ Dull ☐ Ache ☐ Sharp ☐ Shooting ☐ Burning ☐ Stabbing ☐ Tingling ☐ Throbbing

On a scale of 0 to 10 (where 0 = no pain and 10 = severe pain) please score your pain when you are: WITHOUT activity? _____

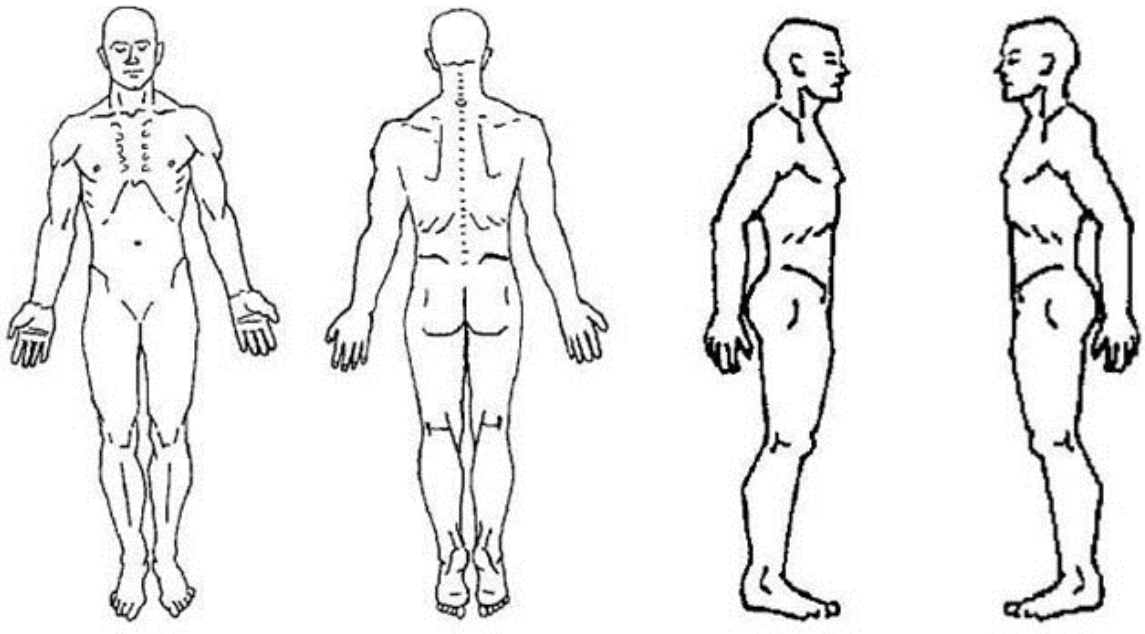
WITH activity? _____

What medications are you currently taking to control your pain: _____

_____

LOCATION OF PAIN/ COMPLAINT

Please mark the figures below to reflect where you are experiencing your pain/ complaint.



To the best of my knowledge and ability the information provided is true and complete.

Patient or Guarantor Signature: _____ **Date:** _____

Patient or Guarantor Printed Name: _____ **Relationship to Patient:** _____

CC (Staff Use Only): _____