Surgical Questionnaire (Knee) – Pre-Op

Name: ____________________________________________  Date: ________________

How would you like to be contacted regarding this study: ___ E-Mail/___ Fax /___ Mail

Please give us your Email or Fax: _______________________________________________

How much pain did you have today on a scale of 0 (No pain) to 10 (Worst pain ever):
Before surgery __________

How many pills of narcotics (vicodin, codeine, norco, etc) do you take per day:
Before surgery __________

Did you have pain that woke you up from sleep or at rest without moving:
Before surgery
Night Pain ___ YES / ___ NO    Rest Pain ___ YES / ___ NO

PT Evaluation:

<table>
<thead>
<tr>
<th>ROM</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forward Elevation:</td>
<td>______</td>
</tr>
<tr>
<td>Abduction:</td>
<td>______</td>
</tr>
<tr>
<td>External Rotation:</td>
<td>______</td>
</tr>
</tbody>
</table>

Notes: _______________________________________________________________________________