Surgical Questionnaire (Shoulder) – Month 1 - 6

Name: _____ Date: _____

How much pain did you have at that time on a scale of **0** (No pain) to **10** (Worst pain ever):

Month 1	_____	Month 6	_____
Month 2	_____		
Month 3	_____		
Month 4	_____		
Month 5	_____		

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

Month 1	_____	Month 6	_____
Month 2	_____		
Month 3	_____		
Month 4	_____		
Month 5	_____		

Did you have pain that woke you up from sleep or at rest without moving (Yes/No):

	Night Pain	Rest Pain
Month 1	___ YES / ___ NO	___ YES / ___ NO
Month 2	___ YES / ___ NO	___ YES / ___ NO
Month 3	___ YES / ___ NO	___ YES / ___ NO
Month 4	___ YES / ___ NO	___ YES / ___ NO
Month 5	___ YES / ___ NO	___ YES / ___ NO
Month 6	___ YES / ___ NO	___ YES / ___ NO

For the following questions, please indicate the difficulty of the following activities with a number:
(**0** – Unable to do **1** – Very difficult to do **2** – Somewhat difficult to do **3** – Not difficult to do)

Month	1	2	3	4	5	6
Putting on a coat	____	____	____	____	____	____
Sleeping	____	____	____	____	____	____
Washing your body	____	____	____	____	____	____
Wiping your bottom	____	____	____	____	____	____
Combing your hair	____	____	____	____	____	____
Reaching out	____	____	____	____	____	____
Lifting your arm	____	____	____	____	____	____
Throwing a ball	____	____	____	____	____	____
Working	____	____	____	____	____	____
Playing sports	____	____	____	____	____	____

When did you return to work: _____
Date of Discharge: _____

Please return or fax to Dr. Alan Hirahara at (916) 732-3023.
If you have any questions, please contact my assistant, Heather, at (916) 732-3017.
You may also return the form via email to hvincentsoc@hotmail.com

Surgical Questionnaire (Shoulder) – Month 9 - 24

Name: _____ Date: _____

How much pain did you have at that time on a scale of **0** (No pain) to **10** (Worst pain ever):

Month 9 _____
Month 12 _____
Month 18 _____
Month 24 _____

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

Month 9 _____
Month 12 _____
Month 18 _____
Month 24 _____

Did you have pain that woke you up from sleep or at rest without moving (Circle):

	Night Pain	Rest Pain
Month 9	___ YES / ___ NO	___ YES / ___ NO
Month 12	___ YES / ___ NO	___ YES / ___ NO
Month 18	___ YES / ___ NO	___ YES / ___ NO
Month 24	___ YES / ___ NO	___ YES / ___ NO

For the following questions, please indicate the difficulty of the following activities with a number:
(**0** – Unable to do **1** – Very difficult to do **2** – Somewhat difficult to do **3** – Not difficult to do)

	Month 9	Month 12	Month 18	Month 24
Putting on a coat	_____	_____	_____	_____
Sleeping	_____	_____	_____	_____
Washing your body	_____	_____	_____	_____
Wiping your bottom	_____	_____	_____	_____
Combing your hair	_____	_____	_____	_____
Reaching out	_____	_____	_____	_____
Lifting your arm	_____	_____	_____	_____
Throwing a ball	_____	_____	_____	_____
Working	_____	_____	_____	_____
Playing sports	_____	_____	_____	_____

When did you return to work: _____
Date of Discharge: _____

Please return or fax to Dr. Alan Hirahara at (916) 732-3023.
If you have any questions, please contact my assistant, Heather, at (916) 732-3017.
You may also return the form via email to hvincentsoc@hotmail.com