

Surgical Questionnaire (Shoulder) – 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:
Night Pain Rest Pain
Before surgery ___ 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)

Before surgery

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	_____

PT Evaluation:

	ROM	Strength
Forward Elevation:	_____	_____
Abduction:	_____	_____
External Rotation:	_____	_____

Notes: _____