Saint John's Health Center
PROVIDENCE Health & Services

Center For Hip & Knee Replacement

Office Use Only
Patient Label

MEDICATION LIST

List of Patient's Current Medications

	Name of Medication Include prescription, over-the-counter, samples, vitamins, vaccines, herbal products, respiratory treatments, parenteral nutrition, supplements, and any other FDA substance listed as a drug.	Dose	Frequency	Reason For Medication
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Patient Signature **Date**

Saint John's Health Center
PROVIDENCE Health & Services

Office Use Only
Patient Label

Center For Hip & Knee Replacement

KNOWN ALLERGIES

Height: _____ Weight: _____ □ scale □ self report

Type	List / Describe reaction	**Reaction:** R = Rash D = Difficulty breathing G= GI upset
Medication		
Food		
Environmental		
Latex Products		
Allergy Band		
Other		

Patient Signature **Date**

Saint John's Health Center
PROVIDENCE Health & Services

Office Use Only
Patient Label

Center For Hip & Knee Replacement

Patient Self-Evaluation – Follow Up History

Patient Name: _____

If you have had surgery, when was your surgery performed? _____

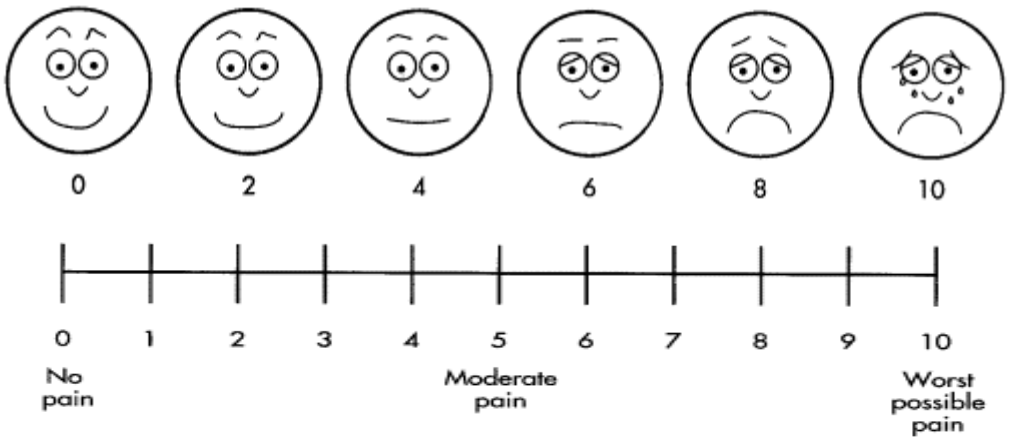
How far or how long are you walking? _____

Are you using a cane or crutches? Never Occasionally Always

Are you driving? Yes No

How often are you taking pain medications? _____

Patient Self-Pain Assessment – Rate your pain:



No Pain	Pain can be ignored	Interferes with tasks	Interferes with concentration	Interferes with basic needs	Bed rest required

Would you like a new prescription for physical therapy? Yes No

Are you back to work? Yes Part time / Full Time No

Are you allergic to penicillin? Yes No

_____ _____

Patient Signature **Date**

Saint John's Health Center
PROVIDENCE | Health & Services

The Center For Hip & Knee Replacement

Office Use Only
Patient Label

PAIN ASSESSMENT QUESTIONNAIRE

To better understand your needs, we would like to know the types of thoughts and feeling that you have when you are in pain. Below are statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end	0	1	2	3	4
I feel I can't go on	0	1	2	3	4
It's terrible and I think it's never going to get any better	0	1	2	3	4
It's awful and I feel that it overwhelms me	0	1	2	3	4
I feel I can't stand it anymore	0	1	2	3	4
I become afraid that the pain will get worse	0	1	2	3	4
I keep thinking of other painful events	0	1	2	3	4
I anxiously want the pain to go away	0	1	2	3	4
I can't seem to keep it out of my mind	0	1	2	3	4
I keep thinking about how much it hurts	0	1	2	3	4
I keep thinking about how badly I want the pain to stop	0	1	2	3	4
There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
I wonder whether something serious may happen	0	1	2	3	4