

# PATIENT QUESTIONNAIRE

## Finding the Right Option For You

Name: \_\_\_\_\_

Date: \_\_\_\_\_

This survey asks for your view about your orthopaedic issues. This information will help us keep identify what options you have tried, what has helped, how you feel about your orthopaedic issue impacting your life and helps us identify the best option that may be right for you.

### For your orthopaedic issue, have you tried the following conservative therapy options before?

	Have you tried this option before? (Check the options you have had)	When was the last time you had this option?	Does it provide relief now? (Circle)	
Physical Therapy	<input type="checkbox"/>		YES	NO
Over the counter anti-inflammatory medicines (aspirin, naproxen, or creams)	<input type="checkbox"/>		YES	NO
Corticosteroids	<input type="checkbox"/>		YES	NO
Hyaluronic acid injections (gel shot)	<input type="checkbox"/>		YES	NO
Prescription pain medications (including opioids)	<input type="checkbox"/>		YES	NO
Other (example PRP, Bone Marrow/BMAC, Amnion)	<input type="checkbox"/>		YES	NO
Change in Activities	<input type="checkbox"/>		YES	NO

### My Livelihood

	YES	NO
Do you live alone? <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel comfortable doing instrumental activities of daily living? <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>
• Preparing food	<input type="checkbox"/>	<input type="checkbox"/>
• Household chores	<input type="checkbox"/>	<input type="checkbox"/>
• Going shopping	<input type="checkbox"/>	<input type="checkbox"/>
• Doing laundry	<input type="checkbox"/>	<input type="checkbox"/>
• Outdoor activities (ex. gardening)	<input type="checkbox"/>	<input type="checkbox"/>
• Driving or using public transportation	<input type="checkbox"/>	<input type="checkbox"/>
Do you have anyone that can assist you with your activities of daily living? <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Are you worried/concerned about needing help from others? <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Are you worried/concerned about taking care of yourself during the recovery process?	<input type="checkbox"/>	<input type="checkbox"/>
Do you worry/concerned about taking care of your children or parents or whomever you are providing care for?	<input type="checkbox"/>	<input type="checkbox"/>
Are you worried/concerned about taking time away from your job or family or activities?	<input type="checkbox"/>	<input type="checkbox"/>

## ● My Point of View

How helpful would surgery be in relieving pain? <sup>1</sup>	<input type="checkbox"/> Helpful with pain	<input type="checkbox"/> Not helpful with pain	<input type="checkbox"/> Do not know
How helpful would surgery be in relieving stiffness? <sup>1</sup>	<input type="checkbox"/> Helpful with stiffness	<input type="checkbox"/> Not helpful with stiffness	<input type="checkbox"/> Do not know
How risky do you think surgery would be for you? <sup>1</sup>	<input type="checkbox"/> Risky	<input type="checkbox"/> Not risky	<input type="checkbox"/> Do not know

	YES	NO
Are you worried or concerned about a long recovery from surgery? <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Are you worried or concerned about discomforts of surgery? <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Are you worried or concerned about complications from surgery? <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Are you worried or concerned about dying from surgery? <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Are you worried or concerned about the long term recovery from surgery? <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Are you worried or concerned about the expense of surgery? <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>
Are you worried or concerned about taking pain medication after surgery?	<input type="checkbox"/>	<input type="checkbox"/>

## ● Considering Other Options

	YES	NO
Are you considering other minimally invasive options?	<input type="checkbox"/>	<input type="checkbox"/>
• Please list options you are considering:	<input type="checkbox"/>	<input type="checkbox"/>
If you are considering other options, would you like a FDA Cleared option?	<input type="checkbox"/>	<input type="checkbox"/>

### Reference:

1. Hamel M et al. Joint Replacement Surgery in Elderly Patients with Severe Osteoarthritis of the Hip and Knee. 2008 American Medical Association. 1430-1440.