# Acute Care Subspecialty Questionnaire

Name: ______________________ Age: ________ Sex: M/F Date:____________

Occupation: ______________________

Dominant Hand: Right Left

How did you injure yourself? ______________________

______________________

Side of Injury: Right Left

Date of Injury: ______________________

Have you had surgery for the injury? Yes No

Name of Surgeon: ______________________

Date of Surgery: ______________________

Where are you living now?

Home Rehab Facility: ______________ Nursing Facility: ______________

Did you use an assistive device to walk before the injury? Yes No

If yes, what type of assistive device? Cane Walker Wheelchair

Do you currently use an assistive device to walk?

If yes, what type of assistive device? Cane Walker Wheelchair

Do you smoke? Yes No

If so, how much (packs/day)? ______________________

Do you drink alcohol? Yes No

If so, how much? ______________________

<u>Do you have any of the medical conditions below?</u>

Diabetes Rheumatoid Arthritis Congestive Heart Failure

Lupus Other Autoimmune Disease History of Blood Clots (DVT/PE)

Osteoporosis (Treatment: ______________________)

Mental Illness (schizophrenia, bipolar disease, depression, anxiety, etc) ______________________

How well is your pain controlled (0-10): ______________________

What medication(s) are you taking for pain control? ______________________

Are you taking blood thinners? Yes No

If so, what type? Enoxaparin Coumadin Aspirin Other: ______________

Are you participating in physical or occupational therapy? Yes No

If so, where and how often? ______________________

Updated: 1/2/2015