



Patient Satisfaction Questionnaire

eform v 3.1

Patient Name: _____

Side: Left (Ignore for Spine)
 Right

Patient ID: _____

Date of review: (complete either the date of review or the follow up period below)

Follow up period: Pre Op OR _____ Weeks / Months / Years (add the delay and circle one)

Patients - please place an X in one box on each line to indicate your response to that question.

How well did the surgery on your joint:

1. Relieve the pain ?

Excellent Very good Good Fair Poor

2. Increase your ability to perform regular activities ?

Excellent Very good Good Fair Poor

3. Allow you to perform heavy work or sport activities (if allowed by Dr) ?

Excellent Very good Good Fair Poor

4. Meet your expectations ?

Excellent Very good Good Fair Poor

5. Would you have the operation again if needed, on another joint ?

Definitely yes Probably yes Possibly not Definitely not

For this part of the questionnaire, simply place a vertical line at the position on the line below, that corresponds accurately with your perception of your answer to the question.
Please ensure that your line crosses the horizontal line, inside the shaded area.

6. How satisfied are you with your medical care?

Least satisfied Most satisfied

7. How normal does your affected joint feel ?

Least Normal Normal

8. How would you rate your pain ?

No Pain Worst possible pain