Dr. Amanda Marshall Rodriguez

Name: _____ **Date:** _____

DOB: _____

Joint Replacement and Orthopaedic Surgery

WHAT IS THE REASON FOR TODAYS VISIT: _____

WHERE IS THE PAIN LOCATED: ____RIGHT HIP ____ LEFT HIP ____ RIGHT KNEE ____ LEFT KNEE ____ BACK

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HOW WOUD YOU DESCRIBE THE PAIN?

____ SHARP ____ THROBBING ____ BURNING ____ DULL ____ TIGHT ____ TINGLING

RATE YOUR PAIN ON A SCALE OF 1-10 **(1 = MINIMAL, 10 = SEVERE PAIN)**: _____

HAVE YOU TRIED ANY OF THE FOLLOWING: ____ TYLENOL ____ ASPIRIN ____ MOTRIN ____ ALEVE _____ CELEBREX _____ MOBIC ____ OTHER: _____

HAVE YOU TRIED INJECTIONS? ____ YES ____ NO HOW MANY? _____

PAST MEDICAL HISTORY

PLEASE LIST ALL OF YOUR MEDICAL PROBLEMS, SUCH AS HIGH BLOOD PRESSURE OR HEART DISEASE

_____

_____

_____

PLEASE LIST ALL OF YOUR PAST SURGERIES, HOSPITALIZATIONS, SEVERE INJURIES (INCLUDE DATE)

_____

_____

_____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? _____

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LIST MEDICATIONS THAT YOU ARE **CURRENTLY** TAKING (INCLUDE NAME & DOSAGE)

_____

_____

_____

WHAT KIND OF WORK DO YOU DO? _____

MARITAL STATUS: ____ SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED

DO YOU HAVE CHILDREN? ____ YES ____ NO HOW MANY? _____

WHO LIVES AT HOME WITH YOU? _____

DO YOU DRINK ALCOHOL? ____ YES ____ NO IF YES, HOW MAY DRINKS PER WEEK _____

DO YOU USE ILLICIT DRUGS? ____ YES ____ NO DESCRIBE: _____

DO YOU SMOKE? ____ YES ____ NO IF YES, HOW MANY PACKS PER DAY _____ FOR HOW LONG _____

DO YOU EXERCISE REGULARLY? ____ YES ____ NO DESCRIBE: _____

DO YOU FOLLOW A SPECIAL DIET? ____ YES ____ NO DESCRIBE: _____

FAMILY HISTORY

MEMBER ALIVE/DECEASE AGE HEALTH STATUS/CAUSE OF DEATH

FATHER: _____

MOTHER: _____

SIBLING: _____

OTHER INFORMATION:

HEIGHT _____ WEIGHT _____