Dr. Amanda Marshall Rodriguez

Name: _____ **Date:** _____

DOB: _____

Joint Replacement and Orthopaedic Surgery

WHO REFERRED YOU TO OUR CLINIC: _____

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? _____

IF YOU ARE HAVING **HIP** PAIN, WHERE IS IT LOCATED?

____ GROIN ____ THIGH ____ BELOW KNEE ____ SIDE OF HIP ____ DOWN THE KNEE ____ DOWN THE FOOT

IF YOU ARE HAVING **KNEE** PAIN, WHERE IS IT LOCATED?

____ INSIDE THE KNEE (CLOSE TO THE OTHER KNEE) ____ FRONT OF THE KNEE (UNDER THE KNEE CAP)

____ OUTSIDE THE KNEE (AWAY FROM THE OTHER KNEE) ____ BACK OF THE KNEE

IS THE PAIN: ____ GETTING WORSE ____ GETTING BETTER ____ STAYING THE SAME

IS THE PAIN: ____ INTERMITTENT ____ CONSTANT

HOW WOUD YOU DESCRIBE THE PAIN?

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

DO YOU HAVE PAIN WHEN YOU: ____ WALK ____ SIT ____ STAND ____ AT NIGHT

IS THE PAIN WORSE WHEN YOU: ____ WALK ____ SIT ____ STAND ____ AT NIGHT

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

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DO YOU HAVE ANY OF THE FOLLOWING?

____ STIFFNESS ____ SWELLING ____ WEAKNESS

DO YOU HAVE A LIMP?

____ NONE ____ SLIGHT ____ MODERATE ____ SEVERE

HOW FAR CAN YOU WALK BEFORE YOU START HAVING PAIN?

____UNLIMITED ____ 4-6 BLOCKS ____ 2-3 BLOCKS ____ INDOORS ____ BED TO CHAIR ONLY

____ UNABLE TO WALK

HOW MANY STAIRS DO YOU WALK UP TO GET INTO YOUR HOME? _____

HOW MANY STAIRS DO YOU WALK UP INSIDE YOUR HOME? _____

DO YOU NEED ASSISTANCE WALKING? ____ NO ____ CANE, LONG WALKS ONLY ____ CANE AT ALL TIMES

____ WALKER ____ WHEEL CHAIR

DO YOU HAVE DIFFICULTY PUTTING ON YOUR SOCKS/SHOES? ____ YES _____ NO ____ WITH ASSISTANCE

CAN YOU SIT COMFORTABLY IN A CHAIR? ____ IF YES, HOW LONG? _____

ARE YOU ABLE TO GET UP FROM A CHAIR? ____ NORMALLY ____ USE ARMS ____ DIFFICULT USING ARMS ____ NEED HELP, UNABLE TO DO ALONE

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

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

WHAT KIND OF INJECTIONS? ____STEROID ____ SYNVISC ____ NONE ____ OTHER: _____

HOW LONG DID YOU GET RELIEF FOR? _____

HAVE YOU TRIED PHYSICAL THERAPY/EXERCISE? ____ YES ____ NO

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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? _____

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

_____

_____

_____

SOCIAL HISTORY

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: _____

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FAMILY HISTORY

MEMBER ALIVE/DECEASE AGE HEALTH STATUS/CAUSE OF DEATH

FATHER: _____

MOTHER: _____

SIBLING: _____

OTHER INFORMATION:

HEIGHT _____ WEIGHT _____

DO YOU CURRENTLY OR HAVE YOU EVER HAD PROBLEMS WITH ANY OF THE FOLLOWING?
(CHECK ALL THAT APPLY)

CONSTITUTIONAL	**SKIN**	**HEMATOLOGIC/BLOOD**	**EYES**
____RECENT WEIGHT LOSS	____PSORIASIS	____BLOOD CLOTS	____WEARS GLASSES
____RECENT FEVERS	____ECZEMA	____ANEMIA	____CATARACTS
GENITOURINARY	**ENDOCRINE**	**EAR/NOSE/THROAT**	**PSYCHIATRIC**
____PROSTATE	____DIABETES	____SINUS PROBLEMS	____DEPRESSION
____KIDNEY PROBLEMS	____THYROID	____ACTIVE DENTAL PROBLEMS	____SCHIZOPHRENIA
CARDIOVASCULAR	**GASTROINTESTINAL**	**NEUROLOGIC**	**RESPIRATORY**
____ HEART ATTACK	____COLITIS	____SEIZURES/EPILEPSY	____ASTHMA
____HEART MURMUR	____DIVERTICULITIS	____POLIO	____BRONCHITIS
____IRREGULAR HEART BEAT	____ULCER	____PARKINSONS DISEASE	____EMPHYSEMA
____HIGH BLOOD PRESSURE	____ HERNIA	____ALZHEIMERS DISEASE	____PNEUMONIA
____HIGH CHOLESTEROL	____LIVER DISEASE	____BALANCE PROBLEMS	____TUBERCULOSIS

MUSCULOSKELTAL	**CANCER**	**OTHER**
____RHEUMATOID ARTHRITIS	WHAT KIND/TREATMENT	_____
____ANKYLOSING SPONDYLITIS	_____	_____
____LUPUS	_____	_____
____OSTEOPOROSIS	_____	_____

IN GENERAL, WOULD YOU SAY YOUR HEALTH IS ____EXCELLENT ____VERY GOOD ____FAIR ____ POOR

DOES YOUR HEALTH NOW LIMIT THESE ACTIVITIES?

MODERATE ACTIVITIES: MOVING A TABLE, PUSHING A VACCUM CLEANER, BOWLING OR PLAYING GOLF

____YES, VERY LIMITED ____YES, SLIGHTLY LIMITED ____ NO, NOT LIMITED AT ALL

DURING THE PAST 4 WEEKS, HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS WITH YOU WORK OR OTHER REGULAR DAILY ACTIVITIES AS A RESULT OF YOUR PHYSICAL HEALTH?

ACCOMPLISHED LESS THAN YOU WOULD LIKE? _____YES _____NO

DIDN'T DO WORK OR OTHER ACTIVITES AS USUAL _____YES _____NO

DURING THE PAST 4 WEEKS, HOW MUCH DID PAIN INTERFERE WITH YOUR NORMAL WORK, INCLUDING HOUSE WORK AND WORK OUTSIDE OF THE HOME?

_____ NOT AT ALL _____ SLIGHTLY _____ MODERATELY _____QUITE A BIT _____EXTREMELY

THE FOLLOWING QUESTIONS RELATE TO HOW YOU HAVE FELT DURING THE PAST 4 WEEKS.

HOW MAY TIEMS DURING THE PAST 4 WEEKS HAVE YOU?

FELT CALM AND PEACEFUL? ___ALWAYS____MOST OF THE TIME ____SOMETIMES ____NONE OF THE TIME

HAD A LOT OF ENERGY? ___ALWAYS____MOST OF THE TIME ____SOMETIMES ____NONE OF THE TIME

FELT DEPRESSED? ____ALWAYS ____MOST OF THE TIME ___SOMETIMES ____NONE OF THE TIME

DURING THE PAST 4 WEEKS, HOW MUCH OF THE TIME HAS YOUR PHYSICAL HEALTH OR EMOTIONAL PROBLEMS AFFECTED YOU VISITING FRIENDS, RELATIVES, ETC.?

____ ALWAYS ____ MOST OF THE TIME ____ SOMETIMES ____ NONE OF THE TIME