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HISTORY FORM

Please read over carefully, and answer as completely as possible.

Patient Name: _____ Age _____ HT _____ WT _____

Date of Evaluation: _____ Email address: _____

Pharmacy name & number: _____

Symptomatic Joint: (circle one) Hip Knee

(circle one) Right Left Both

Are you allergic to any medicine, metals, tape or Iodine? Please list. _____

I. PRESENT ILLNESS

1. Which of the following are you here for(circle)? A. Evaluation and treatment(no surgery) B. Second opinion C. Surgical options.

2. When did you first notice symptoms?

3. History of Illness:

In outline form:

a) Give a brief history of symptoms from onset to present. When possible, record the approximate date of important changes or developments.

b) List other doctors seen for this condition and dates of evaluation and treatment. Please list their phone numbers.

II. PRESENT STATUS

Instructions: Circle the one which best describes your condition.

1. PAIN

- a. None/ ignore
- b. Slight, occasional, no compromise in activity
- c. Mild, no effect on ordinary activity, pain after unusual activity, or use of Aspirin or similar medication
- d. Moderate, tolerable, requires concessions in activity or occasional codeine or similar medication
- e. Severe requiring limitation of activity
- f. Totally disabling

2. FUNCTION

a. GAIT (walking maximum distance)

- 1) Limp: None
Slight
Moderate
Severe
Unable to walk
- 2) Support: None
Cane, long walks only
Cane, full time
One crutch
2 Canes
2 Crutches or walker
Unable to walk
- 3) Distance walked: Unlimited
6 blocks
2-3 blocks
Indoors only
Bed & Chair

b. FUNCTIONAL ACTIVITIES

- 1) Stairs: Normally (one step with one leg, next step with other leg)
Normally but with banister assistance
One step at a time
Not able

PRESENT STATUS(CONT.)

- | | | | |
|----------------------------|---|--------------------|----|
| 2) Socks/Tie shoes: | <u>Right</u> | <u>Left</u> | |
| | With ease | With ease | |
| | With difficulty | With difficulty | |
| | Unable | Unable | |
| 3) Cut toenails | With ease | With ease | |
| | With difficulty | With difficulty | |
| | Unable | Unable | |
| 4) Sitting | Any chair for as long as needed | | |
| | A high chair for only a limited time | | |
| | Unable to sit in any chair comfortably | | |
| 5) Do you have night pain? | Yes | No | |
| | Do you have pain while resting? | Yes | No |
| | Do you have pain on arising from sitting? | Yes | No |

III. PAST HISTORY

1. List all operations you have had	Date(approx)	Complications?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Please list the date of other hospitalizations and reason for admission

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST HISTORY(CONT)

3. Do you have or have you ever had....?

	YES	NO	WHEN?/ONSET?
Heart disease?	_____	_____	_____
Heart Attack?	_____	_____	_____
High Blood Pressure?	_____	_____	_____
Stroke?	_____	_____	_____
Irregular Heartbeats?	_____	_____	_____
Easy Bruising?	_____	_____	_____
Anemia(Low blood count)?	_____	_____	_____
Phlebitis (clots in leg veins)?	_____	_____	_____
Blood Disorders?	_____	_____	_____
Pulmonary Embolus? (blood clot to lungs)	_____	_____	_____
Nerve Paralysis?	_____	_____	_____
Fainting Spells?	_____	_____	_____
Epilepsy (Seizures)?	_____	_____	_____
Other Nervous System Disease?	_____	_____	_____
Skin Disorders?	_____	_____	_____
Thyroid Disease?	_____	_____	_____
Diabetes?	_____	_____	_____
Glaucoma?	_____	_____	_____
Emphysema?	_____	_____	_____
Tuberculosis?	_____	_____	_____
Sleep Apnea?	_____	_____	_____
Drug Addiction?	_____	_____	_____
Sinus Disease?	_____	_____	_____
Stomach Ulcers?	_____	_____	_____
Cirrhosis?	_____	_____	_____
Hepatitis?	_____	_____	_____
Gallstones?	_____	_____	_____
Kidney Disease(Chronic Urine Infections,Prostatitis)?	_____	_____	_____
Cancer?	_____	_____	_____

4. What is the condition of your teeth? (circle one) Good Need repair/extraction

MEDICATIONS:

5. Medications: Please list the names & doses of any medicines you now take or have taken within the last six months.

Name	Dose	Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Have you ever taken Cortisone or Prednisone by mouth or by injection for the joint in question?

7. Do you drink alcohol? _____ If yes,
How many days a week? _____
How many drinks per day? _____

8. Do you smoke? _____ If yes,
How many cigarettes a day? _____
If you used to smoke, how many years did you smoke? _____
How many packs a day? _____

9. Do you drink coffee? _____ How much per day? _____

10. Approximate date of last physical examination? _____

IV. PERSONAL HISTORY

Place of birth: _____

What is the highest level of education you have obtained? _____

Marital Status: Single Married Separated Divorced Widowed
(circle one)

What is your current occupation? _____

Do you live in a private home? _____ Apartment _____ Other? _____

Is your home single level? _____ Multi level? _____

HIP PATIENT SUPPLEMENT
 (only fill out if you are here for your hip)

	Yes	No
If present, where is your pain located?		
Front of hip or groin?	___	___
On the side of hip?	___	___
Buttock or back of hip?	___	___
Does the pain go down the leg?	___	___
If yes, how far? _____		
Front or back of leg? _____		
Do you have or have you had a problem with low back pain?	___	___
Have you had back surgery?	___	___
Do you use a lift on your shoes?	___	___
Does your hip feel worse after a little walking?	___	___
Did you have a problem with your hip in childhood?	___	___
Do you require assistance of your arms or somebody helping you to get out of a chair?	___	___
Are you unable to work because of your hip problem?	___	___
If yes, will you return to work if the hip problem is corrected?	___	___
Do you require medication to relieve the pain?	___	___
If yes, please list: _____		
Does your hip condition prevent exercise or sport activities?	___	___
If yes, list exercise or sport unable to perform _____		
Have you given up any of the following activities because of your hip problem?		
Gardening?	___	___
Travel?	___	___
Home maintenance or cleaning?	___	___
Sports activity?	___	___
Other, please list _____		