

Vasilios Mathews, M.D.
7401 S. Main
Houston, TX. 77030

HISTORY FORM

Please complete the following and bring it with you to your appointment.

Patient Name: _____ Age _____ HT _____ WT _____

Symptomatic Joint: (circle) Hip Knee
(circle) Right Left Both

Who has referred you to see us? _____

Who is your Primary Care Doctor (*non-orthopedic*) (Name/Address/Phone#)?

Any allergy to any medicine, metals, tape or Iodine? Please list. _____

For what condition or symptoms are you being seen today?

When did the symptoms / condition first occur?

Is this a work injury?

History of *this* Condition: (please list in step by step dated from onset to present)
(If you have a problematic knee/hip replacement, please also list the name of the surgeon who implanted it, along with the hospital and the approximate date)

PAIN SEVERITY (Circle those which best describe your condition)

- a. None/ ignore
- b. Slight, occasional, no compromise in activity
- c. Mild, no effect on ordinary activity, pain after unusual activity, or occasional 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

PAIN LOCATION

KNEE Patients:	Front	Inside	Outside	Back
HIP Patients:	Groin	Side	Buttock	Thigh

GAIT (walking maximum distance)

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

FUNCTION

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

Socks/Tie shoes:	<u>Right</u>	<u>Left</u>
	With ease	With ease
	With difficulty	With difficulty
	Unable	Unable

Sitting: Any chair for as long as needed
High chair for only a limited time
Unable to sit in any chair comfortably

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
Does your pain worsen after walking?	Yes	No
Do you have a history of back pain or back surgery?	Yes	No
Does your condition limit self-care / exercise / work?	Yes	No

PAST HISTORY

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

Please list your medical (non-bone / joint) problems for which you are being treated

_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: Please list the names & doses of any medicines you currently take

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

Do you have a history of Rheumatoid Arthritis? _____

Do you have a Rheumatologist? _____

Have you ever taken Cortisone or Prednisone by mouth or by injection?

Have you had any recent dental work? _____ If yes, when? _____

Do you have current active dental problems and have upcoming dental work? _____

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

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

Do you regularly play any sports? _____

PERSONAL HISTORY

Place of birth: _____

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

What is your current occupation? _____

Are you currently on disability? _____

Is your home single level? _____ Multi level? _____

With whom do you live? _____

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

	YES	NO	WHEN? / ONSET?
Heart Disease?	_____	_____	_____
Heart Attack?	_____	_____	_____
High Blood Pressure?	_____	_____	_____
Stroke?	_____	_____	_____
TIA (mini-stroke)?	_____	_____	_____
Irregular Heartbeat (on EKG)?	_____	_____	_____
Anemia(Low blood count)?	_____	_____	_____
Blood Disorders?	_____	_____	_____
Phlebitis (Blood clots)?	_____	_____	_____
Pulmonary Embolus? (blood clot to lungs)	_____	_____	_____
Sleep Apnea?	_____	_____	_____
Nerve Paralysis?	_____	_____	_____
Fainting Spells?	_____	_____	_____
Parkinson's Disease?	_____	_____	_____
Epilepsy (Seizures)?	_____	_____	_____
Other Nervous System Disease?	_____	_____	_____
Skin Disorders?	_____	_____	_____
Thyroid Disease?	_____	_____	_____
Diabetes?	_____	_____	_____
Foot or Leg Ulcers?	_____	_____	_____
Glaucoma?	_____	_____	_____
Pneumonia?	_____	_____	_____
Emphysema?	_____	_____	_____
Sinus Disease?	_____	_____	_____
HIV / AIDS?	_____	_____	_____
Tuberculosis?	_____	_____	_____
Stomach Ulcers?	_____	_____	_____
Cirrhosis?	_____	_____	_____
Hepatitis?	_____	_____	_____
Gallstones?	_____	_____	_____
Kidney Disease?	_____	_____	_____
Chronic Urine Infections?	_____	_____	_____
Prostate Problems?	_____	_____	_____
Cancer? Type?	_____	_____	_____
Alcohol Addiction?	_____	_____	_____
Drug Addiction / Abuse?	_____	_____	_____

Dear Patient:

We are pleased that you have selected Dr. Mathews to evaluate and treat your knee or hip condition. In order to facilitate your care, we have the following office policies. Please read them closely and ask us to clarify any questions that you may have.

- 1) Dr. Mathews is trained as a knee and hip surgeon. He has absolutely no training in pain management. Inasmuch, he does not and will not prescribe medications for treatment of chronic pain and in those patients who have no need for surgery. Ample pain medicine is provided in the hospital for patients after surgery and for 6 weeks after discharge. Patients with pain management problems will be referred to their primary care provider or to a pain management specialist.
- 2) In those patients in whom a medication was prescribed, refills may be requested only during office hours: M-Th 9:00 am – 4:00pm and Friday 9:00am-12:00pm. ***Fondren Orthopedic Group policy is to not accept calls for pain medication refills after hours or on weekends.***
- 3) We respect the value of your time and will make effort to remain on schedule. You will find that Dr. Mathews will give you his attention during the visit. Due to the nature of a surgery practice, emergencies will on rare occasion cause us to be late or necessitate office visit rescheduling. In that event, we will make every attempt to contact you ahead of time.
- 4) Disability forms are time-consuming for our staff and physician, and cannot be completed during clinic hours. Please allow several days for their completion. Be sure to complete your portion of the form before you leave it with us and provide a stamped, addressed envelope. Although we are happy to fill out forms for our patients, the time demands placed on our staff for such non-medical forms are significant. As a result, we must charge a \$25 *fee* for each form. We regret any inconvenience this may cause.
- 5) If you have any accounting or billing inquiries, please ask the insurance department when you reach our operator.

Please sign below to indicate that you have received and fully understand these policies.

Signature _____ Date _____

