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HISTORY FORM

Please read carefully and answer as completely as possible.

PATIENT NAME: ____________________________ **Age**______ **HT** _____ ____ **WT** ______lbs

Who referred you to see us? ________________________ E-mail address: ____________________

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

____

Is this a work injury? Yes _____ No ______ If yes, date of injury_____________

Are you **ALLERGIC** to any medicines, tape or iodine? Please list:

____

Are you **ALLERGIC** to any **METALS** of any kind, (**JEWELRY, EARRINGS, or NICKEL**)?
Please list:

PAIN LOCATION (circle all that apply)

Knee:	Right:	Front	Inside	Outside	Back
	Left:	Front	Inside	Outside	Back
Hip:	Right	Groin	Side	Buttock	Thigh
	Left:	Groin	Side	Buttock	Thigh

SYMPTOMS (Please circle those that apply)

Pain Stiffness Restricted motion Popping/crunching Giving way

How long have the symptoms / condition been present? __________________________

HISTORY OF THIS CONDITION: (please list in step by step dated from onset to present):
(Please include ***injury*** or ***prior surgery*** related to this joint)

____

____

____

____

PAIN SEVERITY (Please circle the one which best describes your condition)

a. ☺ **0/10 -** None
b. **2/10 -** Slight, occasional, no compromise in activity
c. **4/10 -** Mild, no effect on ordinary activity, pain after unusual activity, or occasional use of Aspirin or similar medication
d. **6/10** - Moderate, tolerable, requires concessions in activity or occasional codeine or similar medication
e. **8/10 -** Severe, requiring limitation of activity
f. ☹ **10/10 -** Totally disabling

Was the pain less severe 2 years ago? ____

PAIN CHARACTERISTICS

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
Do you have pain when initiating an activity?	Yes	No
Does your pain worsen after walking or weight-bearing?	Yes	No

What makes the pain worse? ____

What makes the pain better? ____

GAIT (circle whichever applies)

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

FUNCTION
Does your condition limit?:

a.	Putting on socks and shoes	Yes	No
b.	Home chores	Yes	No
c.	Stairs	Yes	No
d.	Self-care / Dressing / Bathing	Yes	No
e.	Toileting	Yes	No
f.	Exercise	Yes	No
g.	Work	Yes	No

PREVIOUS TREATMENTS FOR THIS JOINT *(please circle the ones that you've had)*

a. Over-the-counter anti-inflammatory medication such as: Ibuprofen / Advil / Aleve / Motrin
b. Prescription anti-inflammatory such as: Celebrex / Mobic / Naproxen / Other___________
c. Pain medications such as: Tylenol / Ultram / Hydrocodone / other Narcotics____________
d. Cortisone injection in the joint - When? ___________ Doctor? ____________________
e. Joint lubricant ("rooster comb") injection - When? _________ Doctor? _______________
f. Physical Therapy - If yes, how long? _________________ Did it help? ______________
If no, do you think it would hurt too much? ______________________
g. Home Exercise Program
h. Brace
i. Orthopedic Surgeries ____

OFFICE POLICIES AND PROCEDURES

Dear Patient:

We are pleased that you have selected Dr. Goytia 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. Goytia is a trained knee and hip surgeon. He is not a pain management specialist. Therefore, he does not prescribe narcotic pain medication for treatment of chronic pain. Ample pain medicine is provided in the hospital for patients after surgery and for 6 weeks post-operatively. Patients with persistent pain will be referred to their primary care provider or to a pain management specialist.

2) We respect the value of your time and make every effort to remain on schedule. However, due to the nature of Dr. Goytia's practice, emergencies may cause us to be late or necessitate rescheduling office visits. In that event, we will make every effort to contact you ahead of time. Please provide us with alternative methods of contact for you, such as an e-mail address.

3) Patient care is the main priority for Dr. Goytia and his staff. Although we understand that disability forms may be required by your employer or creditor, we cannot complete these forms during clinic hours. **Please allow 7 to 10 days for their completion**. Be sure to complete your portion of the form and provide a fax number to avoid delay.

4) If you have any accounting or billing inquiries, please request the insurance department when calling our main number.

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

Signature ______________________________ Date _________________________