

PATIENT INFORMATION SHEET

BACKGROUND

Name: _____ Date: _____

Age: _____ Ht: _____ Wt: _____ MALE FEMALE

Hobbies/Sports/Exercise Activities: _____

Who Referred You?: _____ MD Friend Patient

If referred by MD, include address & phone number: _____

Physicians who follow you regularly (PCP, cardiologist, etc.):

ALLERGIES (Please list any known drug allergies)

CURRENT MEDICATIONS (List name & dose of medication):

SOCIAL HISTORY

Occupation: _____ Full Time Part Time Student

If not working, are you: Retired On Disability Unemployed

Do you smoke? Yes Never Former – Year Quit _____ If yes, how many packs per day? _____

Do you drink alcohol? Yes – how much? _____ No

Have you ever had a problem with drug dependence? Yes No

Marital status: Married Single Divorced Widowed

Are you pregnant: YES NO Children: Yes No How many? _____

Who lives with you?: _____

SURGICAL HISTORY: (List any past surgeries, including the month/year of surgery)

<input type="checkbox"/> Appendectomy _____	<input type="checkbox"/> Knee Arthroscopy _____
<input type="checkbox"/> Tonsillectomy _____	<input type="checkbox"/> Total Knee Replacement _____
<input type="checkbox"/> Hernia Repair _____	<input type="checkbox"/> Total Hip Replacement _____
<input type="checkbox"/> Gallbladder _____	<input type="checkbox"/> _____
<input type="checkbox"/> Hysterectomy _____	<input type="checkbox"/> _____

Have you ever had a surgical infection? YES NO (If yes, where? _____)

Have you ever had general anesthesia? YES NO

Any Problems with Anesthesia? YES NO (Problem: _____)

Have you ever had radiation or chemotherapy? YES NO (If yes, what kind? _____)

EMORY

ORTHOPAEDICS &
SPINE CENTER

PAST MEDICAL HISTORY: (Please choose all current and past medical conditions)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> No medical problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Blood clots in legs/lungs |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Anorexia/bulemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding disorders | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Anemia | |

FAMILY HISTORY: (Indicate conditions that run in your close family)

- | <u>Condition</u> | <u>Relationship</u> | <u>Condition</u> | <u>Relationship</u> |
|--|---------------------|--|---------------------|
| <input type="checkbox"/> Arthritis | _____ | <input type="checkbox"/> Cancer: Type: _____ | _____ |
| <input type="checkbox"/> Heart disease | _____ | <input type="checkbox"/> Thyroid Disease: | _____ |
| <input type="checkbox"/> High Blood Pressure | _____ | <input type="checkbox"/> Anesthesia Complications: | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Alcoholism: | _____ |
| <input type="checkbox"/> Bleeding Disorder | _____ | <input type="checkbox"/> Other: | _____ |

REVIEW OF SYSTEMS: (Have you experienced any of the following *recently*)

- | | | |
|--|---|--|
| <u>General</u>
<input type="checkbox"/> Unexplained weight loss
<input type="checkbox"/> Appetite change
<input type="checkbox"/> Fevers or chills
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Marked fatigue
<input type="checkbox"/> Difficulty sleeping | <u>Digestive</u>
<input type="checkbox"/> Nausea or vomiting
<input type="checkbox"/> Stomach pain or ulcers
<input type="checkbox"/> Heartburn/acid
<input type="checkbox"/> Frequent diarrhea
<input type="checkbox"/> Frequent constipation
<input type="checkbox"/> Uncontrolled loss of stool
<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Hemorrhoids | <u>Psychiatric</u>
<input type="checkbox"/> Depression
<input type="checkbox"/> Nervous exhaustion
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Paranoia
<input type="checkbox"/> Obsessive/compulsive behavior |
| <u>Ear, Eyes, Nose, Throat</u>
<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Loss of hearing
<input type="checkbox"/> Ear pain
<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Gum trouble
<input type="checkbox"/> Change of vision | <u>Skin</u>
<input type="checkbox"/> Rashes
<input type="checkbox"/> Frequent itchiness
<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Swollen ankles | <u>Genitourinary</u>
<input type="checkbox"/> Burning on urination
<input type="checkbox"/> Difficulty starting urination
<input type="checkbox"/> Incontinence
<input type="checkbox"/> Pelvic pain
<input type="checkbox"/> Urinate at night more than once |
| <u>Cardiovascular</u>
<input type="checkbox"/> Heart or chest pain
<input type="checkbox"/> Abnormal heartbeat
<input type="checkbox"/> Poor heart function | <u>Neurological</u>
<input type="checkbox"/> Seizures
<input type="checkbox"/> Blackouts/fainting
<input type="checkbox"/> Tremors
<input type="checkbox"/> Headaches/migraines | <u>Lung</u>
<input type="checkbox"/> Cough
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Productive cough or sputum |

REASON FOR VISIT:

EMORY

ORTHOPAEDICS &
SPINE CENTER

How is your pain level today? (Circle) No Pain Severe Pain
0 1 2 3 4 5 6 7 8 9 10

Are you taking anything for you pain? _____

Are you being evaluated for a KNEE or HIP replacement? YES NO
If YES, continue appropriate section below:

KNEE (Check all that apply)

How much pain do you have when walking?

None Mild/Occasional Moderate Severe

How much pain does your knee cause when going up and down stairs?

None Mild/Occasional Moderate Severe

How much pain does your knee cause when you are at rest?

None Mild/Occasional Moderate Severe

How does your knee affect your walking ability? I can walk:

Unlimited 11-20 blocks 5-10 blocks 1-4 blocks
 Less than 1 block Cannot walk at all

How do you go up stairs?

Go up the stairs normally Use the hand rail for balance
 Use the handrail to pull myself up Cannot climb stairs

How do you go down stairs?

Go down the stairs normally Use the hand rail for balance
 Use the handrail to support myself Cannot go down stairs

How do you get out of a chair?

Get out of chair normally Use arm rests for balance
 Use arm rests to push myself Cannot get out of a chair

What type of support do you use when walking?

None Cane 2 Canes Crutches Walker

HIP (Check all that apply)

Pain: None Slight Mild Moderate Severe Disabled

Limp: None Slight Moderate Unable to walk

Usual support needed:

None Single cane for long walks Single cane most of the time
 One crutch 2 canes Walker Unable to walk

I can walk: Unlimited 6 blocks 2-3 blocks Indoors only Unable to walk

How do you climb stairs?

Foot over foot without banister Foot over foot with banister
 Any manner (one step at a time, crawl, etc.) Unable to climb stairs

Are you able to Enter Public Transportation: Yes No

Comfortable sitting in a chair for: 1 hour + ½ hour Unable to sit in a chair

I can put on my shoes and socks: Easily With difficulty Need assistance