Arthroplasty Patient Intake Form

Date: _____

☐ Translator: _____ Language: _____

Reason for Visit: _____

Primary Physician: _____

Place Sticker

☐ Right Hip
Began: ☐ <3mo ☐ 3-6mo ☐ ½-1y ☐ 1-5y ☐ >5y
Timing: ☐ Old ☐ New ☐ On/Off ☐ Constant
☐ Now Worse
Quality: ☐ Stiff ☐ Sharp ☐ Stabbing ☐ Dull ☐ Achy
☐ Throbbing ☐ Lightning ☐ Tingling ☐ Numb
☐ Other: _____
Severity out of 10 (10 = worst pain ever): _____
Location: ☐ Groin ☐ Side ☐ Thigh ☐ Buttock
Travels to: ☐ Back ☐ Knee ☐ Foot
Worse with: ☐ Standing ☐ Sitting ☐ Lying Down
☐ On/Off Shoes ☐ In/Out Car
☐ Up/Down Chair ☐ Kneel/Squat
☐ Up Stairs ☐ Down Stairs
☐ Walking
☐ Short Distances ☐ <5 blocks
☐ <1 mile ☐ Cannot Walk at All
☐ Exercise - Type: _____
☐ Sleeping
Better with: ☐ Standing ☐ Sitting ☐ Lying Down
☐ Rest ☐ Activity ☐ Medications

☐ Left Hip
Began: ☐ <3mo ☐ 3-6mo ☐ ½-1y ☐ 1-5y ☐ >5y
Timing: ☐ Old ☐ New ☐ On/Off ☐ Constant
☐ Now Worse
Quality: ☐ Stiff ☐ Sharp ☐ Stabbing ☐ Dull ☐ Achy
☐ Throbbing ☐ Lightning ☐ Tingling ☐ Numb
☐ Other: _____
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Worse with: ☐ Standing ☐ Sitting ☐ Lying Down
☐ On/Off Shoes ☐ In/Out Car
☐ Up/Down Chair ☐ Kneel/Squat
☐ Up Stairs ☐ Down Stairs
☐ Walking
☐ Short Distances ☐ <5 blocks
☐ <1 mile ☐ Cannot Walk at All
☐ Exercise - Type: _____
☐ Sleeping
Better with: ☐ Standing ☐ Sitting ☐ Lying Down
☐ Rest ☐ Activity ☐ Medications

☐ Right Knee
Began: ☐ <3mo ☐ 3-6mo ☐ ½-1y ☐ 1-5y ☐ >5y
Timing: ☐ Old ☐ New ☐ On/Off ☐ Constant
☐ Now Worse
Quality: ☐ Stiff ☐ Sharp ☐ Stabbing ☐ Dull ☐ Achy
☐ Throbbing ☐ Lightning ☐ Tingling ☐ Numb
☐ Other: _____
Severity out of 10 (10 = worst pain ever): _____
Location: ☐ Front ☐ Deep ☐ Inside ☐ Outside
Travels to: ☐ Foot
Worse with: ☐ Standing ☐ Sitting ☐ Lying Down
☐ On/Off Shoes ☐ In/Out Car
☐ Up/Down Chair ☐ Kneel/Squat
☐ Up Stairs ☐ Down Stairs
☐ Walking
☐ Short Distances ☐ <5 blocks
☐ <1 mile ☐ Cannot Walk at All
☐ Exercise - Type: _____
☐ Sleeping
Better with: ☐ Standing ☐ Sitting ☐ Lying Down
☐ Rest ☐ Activity ☐ Medications

☐ Left Knee
Began: ☐ <3mo ☐ 3-6mo ☐ ½-1y ☐ 1-5y ☐ >5y
Timing: ☐ Old ☐ New ☐ On/Off ☐ Constant
☐ Now Worse
Quality: ☐ Stiff ☐ Sharp ☐ Stabbing ☐ Dull ☐ Achy
☐ Throbbing ☐ Lightning ☐ Tingling ☐ Numb
☐ Other: _____
Severity out of 10 (10 = worst pain ever): _____
Location: ☐ Front ☐ Deep ☐ Inside ☐ Outside
Travels to: ☐ Foot
Worse with: ☐ Standing ☐ Sitting ☐ Lying Down
☐ On/Off Shoes ☐ In/Out Car
☐ Up/Down Chair ☐ Kneel/Squat
☐ Up Stairs ☐ Down Stairs
☐ Walking
☐ Short Distances ☐ <5 blocks
☐ <1 mile ☐ Cannot Walk at All
☐ Exercise - Type: _____
☐ Sleeping
Better with: ☐ Standing ☐ Sitting ☐ Lying Down
☐ Rest ☐ Activity ☐ Medications

Please Share Any Details You Feel We May Have Missed:_____

_____

☐ **Spine/Low Back**
Began: ☐ <3mo ☐ 3-6mo ☐ ½-1y ☐ 1-5y ☐ >5y
Timing: ☐ Old ☐ New ☐ On/Off ☐ Constant
☐ Now Worse
Quality: ☐ Stiff ☐ Sharp ☐ Stabbing ☐ Dull
☐ Achy ☐ Throbbing ☐ Lightning
☐ Tingling ☐ Numb ☐ Other: _____
Severity out of 10 (10 = worst pain ever): _____
Location: ☐ Low Back ☐ Buttock
Travels to: ☐ Knee ☐ Foot

Worse with: ☐ Standing ☐ Sitting ☐ Lying Down
☐ On/Off Shoes ☐ In/Out Car
☐ Up/Down Chair ☐ Kneel/Squat
☐ Up Stairs ☐ Down Stairs
☐ Walking
☐ Short Distances ☐ <5 blocks
☐ <1 mile ☐ Cannot Walk at All
☐ Exercise - Type: _____
☐ Sleeping
Better with: ☐ Standing ☐ Sitting ☐ Lying Down
☐ Rest ☐ Activity ☐ Medications

Please Share Any Details You Feel We May Have Missed:_____
_____

I have tried the following to treat my pain (place an 'X'):
☐ Ice ☐ Heat ☐ Weight Loss ☐ Physical Therapy ☐ Brace ☐ Cane ☐ Crutch(es) ☐ Walker ☐ Wheelchair
☐ Tylenol/Acetomenophen ☐ Ultram/Tramadol
☐ Anti-inflammatories: ☐ Ibuprofen/Motrin/Advil ☐ Aleve/Naproxen ☐ Celecoxib/Celebrex ☐ Other: _____
☐ Herbals: ☐ Glucosamine/Chondroitin ☐ Other:_____
☐ Narcotics: ☐ Norco ☐ Percocet ☐ Other:_____
☐ Injections: ☐ Steroid/Cortisone ☐ Synvisc, Orthovisc, Euflexxa, Hyalgan, or Supartz
☐ Surgery – Please list in Surgery Section to Follow
☐ Other:_____

Leg Length: ☐ Equal Length ☐ My Right is Longer ☐ My Left is Longer

Sitting: ☐ In Any Chair for 1h ☐ A High Chair Only for 30min ☐ Unable to Sit without Pain

Walking Support: ☐ None ☐ for Hip Pain ☐ for Knee Pain ☐ for Limp ☐ for Balance/Stability

Maximum Walking Distance, WITHOUT Support: ☐ None ☐ Indoors ☐ 1-3 Blocks ☐ Unlimited

Maximum Walking Distance, WITH Support: ☐ None ☐ Indoors ☐ 1-3 Blocks ☐ Unlimited

Can you go up/down Stairs: ☐ No ☐ Two Feet on Each Step
☐ One Foot on Each Step with Railing
☐ One Foot on Each Step without Railing

Your Highest Level of Activity:
☐ Heavy Labor/Vigorous Sports (High Impact)
☐ Moderate Labor/Sports (Lifting, Running)
☐ Light Labor/Sports (House Cleaning, Yard Work)
☐ Partially Sedentary (Housework, Desk Work)
☐ Sedentary (Minimal Activity)
☐ Bedridden or Wheelchair Bound

Please Share Any Details You Feel We May Have Missed:_____
_____

Past and Current Medical History (Have you been diagnosed with any of these issues?)

General
- ☐ Anxiety
- ☐ Depression/Bipolar
- ☐ Parkinson's Disease
- ☐ Delirium/Dementia
- ☐ Drug/Alcohol Addiction

Skin
- ☐ Varicose Veins
- ☐ Psoriasis
- ☐ Non-healing Wound/Ulcer
- ☐ Radiation Exposure/Treatment

Endocrine
- ☐ Diabetes on Insulin
- ☐ Diabetes not on Insulin
- ☐ Hypothyroid
- ☐ Osteoporosis
- ☐ Prior Spine/Hip/Wrist Fracture

Immunity
- ☐ Rheumatoid Arthritis
- ☐ Multiple Infections
- ☐ Autoimmune Disorder
- ☐ Organ Transplantation (Specify)

Heart
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Atrial Fibrillation
- ☐ Irregular Heart Beat (Specify)
- ☐ Pacemaker/Defibrillator
- ☐ Heart Attack with Stent
- ☐ Heart Attack without Stent
- ☐ Heart Failure

Respiratory
- ☐ Asthma/COPD/Emphysema
- ☐ Sleep Apnea
- ☐ Pulmonary Embolism (PE)

Other
- ☐ Gout/Pseudogout
- ☐ Stroke
- ☐ Seizures
- ☐ Cancer (Specify)

Abdominal
- ☐ Gastric Reflux Disease
- ☐ Stomach Ulcer
- ☐ Hepatitis/Liver Failure
- ☐ Multiple Urinary Tract Infections
- ☐ Kidney/Renal Failure
- ☐ Dialysis

Blood
- ☐ Anemia
- ☐ Blood Clot
- ☐ Deep Venous Thrombosis (DVT)
- ☐ Easy Bruising
- ☐ Hemophilia

Please Specify or Clarify Any Medical Issue(s), Especially those Not Listed Above:

Past Surgeries (list all prior surgeries, including those on your joints) ☐ None

Type of Surgery	Location	Year	Surgeon	Hospital

Prescription, Herbal, and Over-the-Counter Medications ☐ List Attached ☐ None

Medication	Dose	Frequency	Reason

Allergic Reactions ☐ List Attached ☐ None

Medication/Item	Reaction

Medical Problems that Run in Your Family (Mother, Father, Siblings, Children) ☐ None

Family Member	Age	Deceased (Y/N)	Medical Issue(s)

Personal Demographics

Racial Background: ☐ Caucasian ☐ Hispanic ☐ Asian/Pacific Islander ☐ Black/African American
☐ American Indian/Alaskan Native ☐ Multiracial ☐ Other: _____

Birthplace: _____ Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Occupation: List Current Occupation and Position/Title: _____
☐ Employed Full-time ☐ Employed Part-time ☐ Student ☐ Homemaker ☐ Retired
☐ Unemployed ☐ Disabled

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Living Situation: ☐ Live Alone ☐ Live with Spouse/Relatives ☐ Nursing/Care Facility

Alcohol Use: ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially
Began Using: _____ Drinks/Week: _____ Year Quit: _____

Smoking/Tobacco Use: ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially
Began Using: _____ Packs/Day: _____ Year Quit: _____

Illicit Drug Use: ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially
☐ Marijuana ☐ Cocaine ☐ Heroine ☐ Methamphetamine
Began Using: _____ Year Quit: _____

In the past two weeks, how often have you felt down, depressed, or hopeless:
☐ Not at All ☐ Several Days ☐ More than Half of the Days ☐ Nearly Every Day

In the past two weeks, have you had any thoughts of suicide:
☐ None ☐ Thoughts of Death ☐ Thoughts of Suicide ☐ Attempts at Suicide

Medical Review of Systems (Have you had any of these issues recently?)

General Health
☐ Change in Weight
☐ Change in Appetite
☐ Fever/Chills/Sweats
☐ Fatigue

Psychiatric
☐ Anxiety
☐ Depression
☐ Change in Sleep

Skin
☐ Recurrent Rash
☐ Changing Mole
☐ Non-healing Wound/Ulcer
☐ New Lump

Eyes/Ears/Nose/Throat
☐ Blurry/Double Vision
☐ Blindness
☐ Ringing in the Ears
☐ Deafness
☐ Nose Bleed
☐ Mouth Sores
☐ Sore Throat
☐ Vocal Change

Stomach/Intestines
☐ Abdominal Pain
☐ Heartburn
☐ Vomiting
☐ Yellowing of the Skin or Eyes
☐ Diarrhea
☐ Constipation
☐ Bloody Stools

Genitourinary
☐ Burning with Urination
☐ Bloody Urine
☐ Poor Urinary Stream
☐ Incontinence
☐ Change in Sexual Function
☐ Change in Sexual Interest
☐ Scrotal Mass
☐ Pain with Menstruation
☐ Abnormal Uterine Bleeding

Respiratory
☐ Wheezing
☐ Short of Breath
☐ Cough

Neurologic
☐ Headaches
☐ Numbness
☐ Seizures
☐ Loss of Memory

Musculoskeletal (not described above)
☐ Pain
☐ Cramping
☐ Weakness
☐ Inability to Walk

Heart
☐ Passing Out
☐ Chest Pain
☐ Palpitations
☐ Swelling of Hands/Feet

Hematologic
☐ Blood Clots
☐ Easy Bruising
☐ Frequent Bleeding
☐ Enlarged Lymph Nodes

Other
☐ Multiple Infections
☐ Heat/Cold Intolerance
☐ Excessive Thirst/Urination