Arthroplasty Patient Intake Form

Date: ______

☐ Translator: ______ Language: ______

Reason for Visit: ____________________________

Primary Physician: __________________________

☐ 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

☐ 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 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): ______
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☐ Left Knee
Began: □ <3mo □ 3-6mo □ ½-1y □ 1-5y □ >5y
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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
Better with: □ Standing □ Sitting □ Lying Down
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
□ 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?)

<table>
<thead>
<tr>
<th>General</th>
<th>Skin</th>
<th>Endocrine</th>
<th>Immunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Varicose Veins</td>
<td>Diabetes on Insulin</td>
<td>Rheumatoid Arthritis</td>
</tr>
<tr>
<td>Depression/Bipolar</td>
<td>Psoriasis</td>
<td>Diabetes not on Insulin</td>
<td>Multiple Infections</td>
</tr>
<tr>
<td>Parkinson’s Disease</td>
<td>Non-healing Wound/Ulcer</td>
<td>Hypothyroid</td>
<td>Autoimmune Disorder</td>
</tr>
<tr>
<td>Delirium/Dementia</td>
<td>Radiation Exposure/Treatment</td>
<td>Osteoporosis</td>
<td>Organ Transplantiation (Specify)</td>
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<tr>
<td>Drug/Alcohol Addiction</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Heart</th>
<th>Respiratory</th>
<th>Abdominal</th>
<th>Blood</th>
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</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td>Asthma/COPD/Emphysema</td>
<td>Gastric Reflux Disease</td>
<td>Anemia</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Sleep Apnea</td>
<td>Stomach Ulcer</td>
<td>Blood Clot</td>
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<tr>
<td>Atrial Fibrillation</td>
<td>Pulmonary Embolism (PE)</td>
<td>Hepatitis/Liver Failure</td>
<td>Deep Venous Thrombosis (DVT)</td>
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<tr>
<td>Irregular Heart Beat (Specify)</td>
<td></td>
<td>Multiple Urinary Tract Infections</td>
<td>Easy Bruising</td>
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<tr>
<td>Pacemaker/Defibrillator</td>
<td></td>
<td>Kidney/Renal Failure</td>
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<tr>
<td>Heart Attack with Stent</td>
<td>Gout/Pseudogout</td>
<td>Dialysis</td>
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<tr>
<td>Heart Attack without Stent</td>
<td>Stroke</td>
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<td>Heart Failure</td>
<td>Seizures</td>
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<td></td>
<td>Cancer (Specify)</td>
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| Other                            |                                    |                                    |                                    |

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

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### Past Surgeries (list all prior surgeries, including those on your joints)

<table>
<thead>
<tr>
<th>Type of Surgery</th>
<th>Location</th>
<th>Year</th>
<th>Surgeon</th>
<th>Hospital</th>
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### Prescription, Herbal, and Over-the-Counter Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Reason</th>
<th>List Attached</th>
<th>None</th>
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### Allergic Reactions

<table>
<thead>
<tr>
<th>Medication/Item</th>
<th>Reaction</th>
<th>List Attached</th>
<th>None</th>
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### Medical Problems that Run in Your Family (Mother, Father, Siblings, Children)

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age</th>
<th>Deceased (Y/N)</th>
<th>Medical Issue(s)</th>
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3
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 ☐ Heroin ☐ 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