Arthroplasty History & Physical

Name: **Age:** **Date:**

What is the main reason for your visit today?	Patient Sticker
Height: **Weight:**	
Circle a number from 0-10 that best describes how much pain you are having **RIGHT NOW.** No pain — Moderate pain — Unbearable pain 0 1 2 3 4 5 6 7 8 9 10	For a child or non-english speaking adult, use the  FACES© pain rating scale below:

Please list any **ALLERGIES** you have to <u>medications or food/substances:</u>	☐ None
Please list all **prescription medications** and the dose that you take (or provide a list):	☐ None
Please indicate your **preferred** pharmacy with name/city/zip:	

When did your symptoms start? **Are symptoms getting worse?** ☐ Yes ☐ No

Where do you feel the pain? (check/circle)

☐ Front of Knee R / L ☐ Back of the knee R / L ☐ Inside of the knee R / L ☐ Outside of the knee R / L

☐ Buttock area R / L ☐ Side of Hip R / L ☐ Hip groin (front of hip) R / L ☐ Thigh R / L

☐ Numbness and tingling in the foot

☐ Pain Radiates to knee R / L

☐ Pain radiates to foot R / L

How do you describe the pain?

☐ Dull ☐ Aching ☐ Sharp ☐ Throbbing

☐ Burning ☐ Shooting ☐ Swollen ☐ Stiff

Do you have pain/difficulty with:

☐ Stairs ☐ Standing ☐ Walking

☐ Only with activity ☐ Sitting ☐ During day

☐ At night ☐ Putting on shoes and sock

☐ All the time

Do you have a limp? ☐ Yes ☐ No

Do you require a walking aid? Which type?

☐ Cane ☐ Walker ☐ Other _____

Current activity level? (i.e. gym, swimming, biking, walking, golf)? _____

Number of blocks you can walk without pain or stopping? _____

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Past Surgical History:

	Date		Date		Date
☐ Brain Surgery		☐ Total Hip Surgery		☐ Transplant–	
☐ Shoulder Surgery		☐ Partial Hip Surgery		Please list (kidney, bone marrow, etc.)	
☐ Heart Surgery		☐ Hip Arthroscopy		_____	
☐ Abdominal Surgery		☐ Total Knee Surgery		☐ Other (explain)	
☐ Hip/Femur Fracture Surgery		☐ Partial KneeSurgery		_____	
☐ Other Fracture Surgery		☐ Knee Arthroscopy		_____	

Other pertinent details of history include:

What treatments have you tried: ☐ None

☐ NSAIDS *(Motrin, Ibuprofen)* Helpful? ☐ Y ☐ N If yes, which medication?

_____

How long taken? _____

☐ Narcotics *(Codeine, Vicodin)* Helpful? ☐ Y ☐ N If yes, which medication?

_____

How long taken? _____

☐ Physical Therapy Helpful? ☐ Y ☐ N If yes, for how long? _____

☐ Weight Gain/Loss Helpful? ☐ Y ☐ N If yes, how much? _____

☐ Knee brace Helpful? ☐ Y ☐ N

☐ Injections Helpful? ☐ Y ☐ N

If you have had an injection before, which medication? ☐ Cortisone ☐ Synvisc, Supartz, hyaluronic acid

When was the last injection? _____

Occupation? _____ ☐ Retired ☐ Disabled ☐ Unemployed

If not working, is this related to the hip or knee problem? ☐ Yes ☐ No

Where do you currently live? ☐ Private Home ☐ Assisted Living ☐ Other **Who do you live with?** _____

If you currently have any symptoms listed below, please circle any that apply:

☐ NONE OF THE BELOW

Recent fevers, chills, night sweats, weight loss or gain, fatigue
Skin rashes, itching, abscesses
Headaches, hearing loss, nosebleeds, throat problem
Vision problems
Chest pain, palpitations, irregular heartbeat, leg swelling
Lung problems, shortness of breath, asthma, chronic cough
Heartburn, nausea, vomiting, abdominal pain, diarrhea, constipation, blood in stool, dark tarry stool
Difficulty or frequent urination, blood in urine, flank pain
Muscle, neck, back, or joint pain, or recent falls
Easy bruising, allergies (grass)
Diabetes, frequent excessive thirst, or other endocrine problems
Dizziness, tremor, loss of sensation in your arms or legs, speech change, focal weakness, loss of consciousness
Depression, suicidal ideations, anxiety, insomnia, memory loss

Today's Visit at MarinHealth Orthopedic Care:

To ensure you get the most out of your appointment, please list below three main concerns you'd like addressed. (As an example: **goals of treatment for today's visit,** review imaging studies, discuss medication management, explore non-operative treatments, etc.)

1. _____
   _____
   _____

2. _____
   _____
   _____

3. _____
   _____
   _____