

Name:							Date of Birth:				/I 🗆 F			
Chief Complaint: Right Left						□ Нір	☐ Knee							
Histor	y of F	Problem												
Durati	ion (L	ength o	f Time):											
Intens	ity of	Pain (S	cale 0-10; 0=N	lo Pain, 10	=Wo	rst P	ain Imagir	nable):						
Past t	reatn	nent for	this problem: _											
Previo	us S	urgeries	on this area:	□ No		□ Ye	es							
	Туן	oe:										Date:		
	Тур	oe:										Date:		
Medic	al Hi	story (Cl	neck all medica	al problems	s you	hav	e been or	currently	are b	eing	treate	ed for):		
N	Υ			•		Υ				N	Υ	,		
		High B	lood Pressure		Г		Stroke					Parkinson's Diseas	<u></u> е	
			Disease/Heart A	Attack			Blood Cl	ots				Multiple Sclerosis		
	+ +		ar Heart Rhythi	m			Diabetes					Seizure/Epilepsy		
	Peripheral Vaso		eral Vascular D	isease	,		Cancer					Nerve Injury		
	Emphysema/COPD/Asthma				Ulcer					Hepatitis A				
	Sleep Apnea				Kidney Disease			Immunodeficiency D						
		Tuberculosis (TB)					Thyroid Disease				Degenerative Spine [e Disease Scia	tica
			D Heartburn			Brain Injury		ury				Arthritis/Osteoporosis		
Curaio	າລI ∐i	etory (Li	st all other sur	aeries vou	have	had		-						
	Year	Story (Li		ype of Sur			1).	Ιv	ear			Type of Su	Irdory	
	Itai		<u> </u>	ype or sur	yery	<u>/</u>		 '	tai			Type of Su	ıı geı y	
Linkal	I Ma	diaatian.	a view telee we are	براموان (نجوان	م مام			- mada).		- A	.	لما الم		
LIST al	i we		s you take regu	liariy (inciu			rescription / Often	i meas):	5			ed List	How Oft	on
Name & Dose					пом	Oiteii	-	Name & Dose				HOW UIL	EII	
								1						
CE	NTE		ORTHOPAED JOINT PRESE W PATIENT Q Page	RVATION UESTION	& RE		ACEMENT	P A T I E N T						

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1206D-2222 (6-16)

WHITE - MEDICAL RECORD

Complications (Check and explain any complications you have had after any of your surgeries): Infection:	Allergies: ☐ No ☐ Yes If y	res, please list medication and rea	ction to it below:					
Infection: Pneumonia: Bleeding: Lung Problems: Blood Clot: Severe Nausea/Vomiting: Other: Other:	Medication	Reaction	Medication		Reaction			
Infection:								
Infection:		L						
Infection: Bleeding: Blood Clot: Anesthesia Reaction: Occupation: Do you drink alcohol? No Yes If yes, how much? 1-5 6-10 11-15 16-20 20 or more Do you currently smoke? No Yes If yes, number of packs per day: For years Did you ever smoke? No Yes If yes, number of packs per day: For years For ye	Complications (Check and explain a	iny complications you have had a	fter any of your surgeries).					
Bleeding: Blood Clot: Anesthesia Reaction: Other:	· · · · · · · · · · · · · · · · · · ·	ing complications you have had a						
Blood Clot: Severe Nausea/Vomiting: Other:								
Anesthesia Reaction: Other:	<u> </u>		· ·					
Occupation:								
Occupation:	'	•	-					
Do you drink alcohol?	Social History:							
Do you drink alcohol?	Occupation		Г	□ Eull Time	□ Dort □ Dotiro			
Do you currently smoke?	occupation:		L		□ Part □ Retire			
Do you currently smoke?	Do you drink alcohol?	Yes If yes, how much? ☐ 1-5	□ 6-10 □ 11-15 □ 16	-20 □ 20 d	or more drinks/week			
Did you ever smoke?		in yee, new maen.		20 🗆 20 (or more drime, weer			
Review of Symptoms (Check any recent/current problems, check symptoms or write in other): N Y System Symptoms/Problems Other General Fever, Unexplained Weight Loss/Gain, Weakness Eyes/Vision Glasses, Blurred, Double, Dry Eyes Ears, Nose, Throat, Mouth Vertigo, Sinusitis, Hoarseness, Loss of Hearing Heart Chest Pain, Murmurs, Palpitations, Irregular Rhythm Lung Short of Breath, Asthma, Cough, Wheezing Circulation Blood Clots, Swelling, Claudication, Varicosities Digestive Tract Diarrhea, Constipation, Ulcers, GERD, Pain Kidney/Urinary Stones, Burning, Itching, Bleeding Skin/Breast Rash, Lump, Itching, Hair or Nails Change Endocrine Excess Thirst, Decreased Energy, Diabetes Neurologic Balance, Numbness/Tingling, Seizure, Tremor	Do you currently smoke? 🗌 No	\square Yes If yes, number of pa	cks per day: l	For ye	ars			
Review of Symptoms (Check any recent/current problems, check symptoms or write in other): N Y System Symptoms/Problems Other General Fever, Unexplained Weight Loss/Gain, Weakness Eyes/Vision Glasses, Blurred, Double, Dry Eyes Ears, Nose, Throat, Mouth Vertigo, Sinusitis, Hoarseness, Loss of Hearing Heart Chest Pain, Murmurs, Palpitations, Irregular Rhythm Lung Short of Breath, Asthma, Cough, Wheezing Circulation Blood Clots, Swelling, Claudication, Varicosities Digestive Tract Diarrhea, Constipation, Ulcers, GERD, Pain Kidney/Urinary Stones, Burning, Itching, Bleeding Skin/Breast Rash, Lump, Itching, Hair or Nails Change Endocrine Excess Thirst, Decreased Energy, Diabetes Neurologic Balance, Numbness/Tingling, Seizure, Tremor								
Review of Symptoms (Check any recent/current problems, check symptoms or write in other): N Y System	Did you ever smoke? $\;\;\square$ No $\;\;\square$ '	Yes If yes, number of pa	cks per day:	For ye	ars Year quit:			
Review of Symptoms (Check any recent/current problems, check symptoms or write in other): N Y System	History of Cubatanaa Abusa?	lo 🗆 Voc. If you what substan	001					
N Y System Symptoms/Problems Other General Fever, Unexplained Weight Loss/Gain, Weakness Beyes/Vision Glasses, Blurred, Double, Dry Eyes Ears, Nose, Throat, Mouth Vertigo, Sinusitis, Hoarseness, Loss of Hearing Loss of Hearing Heart Chest Pain, Murmurs, Palpitations, Irregular Rhythm Lung Short of Breath, Asthma, Cough, Wheezing Circulation Blood Clots, Swelling, Claudication, Varicosities Digestive Tract Diarrhea, Constipation, Ulcers, GERD, Pain Kidney/Urinary Stones, Burning, Itching, Bleeding Skin/Breast Rash, Lump, Itching, Hair or Nails Change Endocrine Excess Thirst, Decreased Energy, Diabetes Neurologic Balance, Numbness/Tingling, Seizure, Tremor	nistory of Substance Abuse?	10 🔲 fes il yes, what substan	ce:					
N Y System Symptoms/Problems Other General Fever, Unexplained Weight Loss/Gain, Weakness Beyes/Vision Glasses, Blurred, Double, Dry Eyes Ears, Nose, Throat, Mouth Vertigo, Sinusitis, Hoarseness, Loss of Hearing Loss of Hearing Heart Chest Pain, Murmurs, Palpitations, Irregular Rhythm Lung Short of Breath, Asthma, Cough, Wheezing Circulation Blood Clots, Swelling, Claudication, Varicosities Digestive Tract Diarrhea, Constipation, Ulcers, GERD, Pain Kidney/Urinary Stones, Burning, Itching, Bleeding Skin/Breast Rash, Lump, Itching, Hair or Nails Change Endocrine Excess Thirst, Decreased Energy, Diabetes Neurologic Balance, Numbness/Tingling, Seizure, Tremor								
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General		· · · · · · · · · · · · · · · · · · ·	nptoms or write in other):					
Eyes/Vision	,	-	/0: ===		Other			
Ears, Nose, Throat, Mouth		<u> </u>	•	SS				
Heart ☐ Chest Pain, ☐ Murmurs, ☐ Palpitations, ☐ Irregular Rhythm Lung ☐ Short of Breath, ☐ Asthma, ☐ Cough, ☐ Wheezing Circulation ☐ Blood Clots, ☐ Swelling, ☐ Claudication, ☐ Varicosities Digestive Tract ☐ Diarrhea, ☐ Constipation, ☐ Ulcers, ☐ GERD, ☐ Pain Kidney/Urinary ☐ Stones, ☐ Burning, ☐ Itching, ☐ Bleeding Skin/Breast ☐ Rash, Lump, ☐ Itching, ☐ Hair or Nails Change Endocrine ☐ Excess Thirst, ☐ Decreased Energy, ☐ Diabetes Neurologic ☐ Balance, ☐ Numbness/Tingling, ☐ Seizure, ☐ Tremor		· · · · · · · · · · · · · · · · · · ·						
Lung Short of Breath, Asthma, Cough, Wheezing Circulation Blood Clots, Swelling, Claudication, Varicosities Digestive Tract Diarrhea, Constipation, Ulcers, GERD, Pain Kidney/Urinary Stones, Burning, Itching, Bleeding Skin/Breast Rash, Lump, Itching, Hair or Nails Change Endocrine Excess Thirst, Decreased Energy, Diabetes Neurologic Balance, Numbness/Tingling, Seizure, Tremor								
Circulation □ Blood Clots, □ Swelling, □ Claudication, □ Varicosities Digestive Tract □ Diarrhea, □ Constipation, □ Ulcers, □ GERD, □ Pain Kidney/Urinary □ Stones, □ Burning, □ Itching, □ Bleeding Skin/Breast □ Rash, Lump, □ Itching, □ Hair or Nails Change Endocrine □ Excess Thirst, □ Decreased Energy, □ Diabetes Neurologic □ Balance, □ Numbness/Tingling, □ Seizure, □ Tremor		 						
Digestive Tract Diarrhea, Constipation, Ulcers, GERD, Pain Kidney/Urinary Stones, Burning, Itching, Bleeding Skin/Breast Rash, Lump, Itching, Hair or Nails Change Endocrine Excess Thirst, Decreased Energy, Diabetes Neurologic Balance, Numbness/Tingling, Seizure, Tremor	Lung							
Kidney/Urinary	Circulation	☐ Blood Clots, ☐ Swelling,	\square Claudication, \square Vario	osities				
Skin/Breast	Digestive Tract	☐ Diarrhea, ☐ Constipation,						
Endocrine	Kidney/Urinary	☐ Stones, ☐ Burning, ☐ If	ching, Bleeding					
Endocrine □ Excess Thirst, □ Decreased Energy, □ Diabetes Neurologic □ Balance, □ Numbness/Tingling, □ Seizure, □ Tremor	Skin/Breast	☐ Rash, Lump, ☐ Itching,	☐ Hair or Nails Change					
Neurologic □ Balance, □ Numbness/Tingling, □ Seizure, □ Tremor	Endocrine	☐ Excess Thirst, ☐ Decrease	ed Energy, 🔲 Diabetes					
	Neurologic	 		emor				
Psychiatric Depressions, Anxiety, Sleep Disorder	- i - i	☐ Depressions, ☐ Anxiety.	☐ Sleep Disorder					
Blood/Lymph ☐ Bleeding Problems, ☐ Easy Bruising, ☐ Transfusion								
Musculoskeletal Fracture, Arthritis, Motion Loss, Cramps/Spasms								

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PAT-EXT -D

Family History (Mark any conditions that your parents or siblings have or have had by indicating the family member [M = mother, F = Father, B = Brother, S = Sister] after the conditions):

High Blood Pressure:	Asthma:	Cancer:					
Heart Attack:	Lung Disease:	Stroke:					
Coronary Artery Disease:	Tuberculosis:	Diabetes:					
Heart Valve Disease:	Thyroid Disease:	Kidney Disease:					
Irregular Heart Rhythm:	Blood Clots:	Arthritis:					
Peripheral Vascular Disease:	Seizures:	Osteoporosis:					
Hepatitis: ☐ A ☐ B ☐ C	Immunodeficiency:	Other:					
I certify that the foregoing statements are tr	rue to the best of my knowledge.						
Patient Signature:		Date:	Time:				
Physician (Print):	(Signature):	Date:	Time:				
Vital Signs:							
Temp: BP: HR:	_ RR: Pain: Height:	Weight:	BMI:				
Narcotics Use Question for Patients Completing Questionnaire: Has it been more than 90 days since the patient's last use of chronic narcotics? \square No \square Yes							
Medical Assistant (Print):	(Signature):	Date:	Time:				

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PATIENT ID