Keck Medical Center of USC

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Department of Orthopaedic Surgery

Patient Medical Health Profile

Patient Name _____

Date of Birth_____ Age _____ [ ] Male [ ] Female

Referring Physician / Individual / Orthopaedic Surgeon (Circle One)

Name _____

Address_____

Phone#_____Fax# _____

Would you like correspondence sent to the above person? [ ] Yes [ ] No

Reason for Visit (Check all that apply)

Hip pain	[ ] Right	[ ] Left	[ ] Both
Groin pain	[ ] Right	[ ] Left	[ ] Both
Thigh pain	[ ] Right	[ ] Left	[ ] Both
Knee pain	[ ] Right	[ ] Left	[ ] Both
Neck/Back pain	[ ] Neck	[ ] Mid back	[ ] Low back

Treatments To Date

[ ] Injections [ ] Therapy [ ] Anti-inflammatory Medicine

(Did any of the above improve symptoms? Y/N)

Briefly Describe Your Symptoms:

_____

_____

_____

_____

DOB:
DOS:
ATT:
FIN:
MRN:

Duration of Pain/Symptoms

[ ] Days [ ] Weeks [ ] Months [ ] Years

Onset of Pain

[ ] Spontaneous [ ] Gradual [ ] Traumatic

Pain Level (choose one)

[ ] No pain
[ ] Mild/Occasional; does not compromise activities; occurs after periods of increased activity
[ ] Mild with stair climbing
[ ] Mild with all walking and stair climbing
[ ] Moderately severe pain, but occasional; forces concessions in daily living; requires Tylenol #3, Vicodin, Lortab, Advil, Celebrex, or Vioxx.
[ ] Moderately severe; continuous pain
[ ] Severe pain; serious limitations and disabling

Do you have trouble sleeping because of your pain?

[ ] Never [ ] Occassionally [ ] Every night

What makes the pain better?_____

Do you feel that you limp?

[ ] No limp [ ] Moderate limp [ ] Unable to walk
[ ] Slight limp [ ] Severe limp

Do you use any assist devices (cane, crutches or walker)?

[ ] None [ ] 2 canes [ ] walker
[ ] 1 cane for long walks [ ] 1 crutch [ ] unable to walk
[ ] 1 cane at all times [ ] 2 crutches

How far can you walk before your pain stops you?

[ ] Unlimited walking [ ] Less than 2 blocks
[ ] More than 10 blocks/30 min [ ] Indoors only
[ ] 2-10 blocks/15 min [ ] Unable to walk

Do you have difficulty walking stairs?

[ ] No difficulty. No need for banister. Reciprocal stairs
[ ] Normal up, difficulty going down
[ ] Reciprocal stairs (one after another) but need banister up or down
[ ] Much difficulty. One stair at a time and need banister.
[ ] Unable to walk stairs

DOB:
DOS:
ATT:
FIN:
MRN:

Name: _____ Date of Birth: _____ ☐ M ☐ F

Chief Complaint: ☐ Right ☐ Left ☐ Both ☐ Hip ☐ Knee

History of Problem: _____

Duration (Length of Time): _____

Intensity of Pain (Scale 0-10; 0=No Pain, 10=Worst Pain Imaginable): _____

Past treatment for this problem: _____

Previous Surgeries on this area: ☐ No ☐ Yes

Type: _____ Date: _____

Type: _____ Date: _____

Medical History (Check all medical problems you have been or currently are being treated for):

N	Y		N	Y		N	Y	
		High Blood Pressure			Stroke			Parkinson's Disease
		Heart Disease/Heart Attack			Blood Clots			Multiple Sclerosis
		Irregular Heart Rhythm			Diabetes			Seizure/Epilepsy
		Peripheral Vascular Disease			Cancer			Nerve Injury
		Emphysema/COPD/Asthma			Ulcer			Hepatitis ☐ A ☐ B ☐ C
		Sleep Apnea			Kidney Disease			Immunodeficiency Disease (HIV)
		Tuberculosis (TB)			Thyroid Disease			Degenerative Spine Disease Sciatica
		GERD Heartburn			Brain Injury			Arthritis/Osteoporosis

Surgical History (List all other surgeries you have had):

Year	Type of Surgery	Year	Type of Surgery

List all Medications you take regularly (include non-prescription meds): ☐ See Attached List

Name & Dose	How Often	Name & Dose	How Often

ORTHOPAEDIC SURGERY
CENTER FOR JOINT PRESERVATION & REPLACEMENT
NEW PATIENT QUESTIONNAIRE

PATIENT ID

DOB:
DOS:
ATT:
FIN:
MRN:

Allergies: ☐ No ☐ Yes If yes, please list medication and reaction to it below:

Medication	Reaction	Medication	Reaction

Complications (Check and explain any complications you have had after any of your surgeries):

	Infection:		Pneumonia:
	Bleeding:		Lung Problems:
	Blood Clot:		Severe Nausea/Vomiting:
	Anesthesia Reaction:		Other:

Social History:

Occupation: _____ ☐ Full Time ☐ Part ☐ Retired

Do you drink alcohol? ☐ No ☐ Yes If yes, how much? ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 20 or more drinks/week

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 Year quit: _____

History of Substance Abuse? ☐ No ☐ Yes If yes, what substance: _____

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	
		Psychiatric	☐ Depressions, ☐ Anxiety, ☐ Sleep Disorder	
		Blood/Lymph	☐ Bleeding Problems, ☐ Easy Bruising, ☐ Transfusion	
		Musculoskeletal	☐ Fracture, ☐ Arthritis, ☐ Motion Loss, ☐ Cramps/Spasms	

PATIENT ID

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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 true 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? ☐ No ☐ Yes

Medical Assistant (Print): _____ (Signature): _____ Date: _____ Time: _____

PATIENT ID

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PHYSICAL EXAM (Physician to fill out)

Ht:	Wt:	Temp:	BP:	HR:	RR:

Gait [ ] Antalgia [ ] Shortened Stance Phase
[ ] Foot Progression in ER [ ] Uses hands to arise from chair

Skin/Nodes [ ] Clear [ ] Rashes [ ] Ulcers

HEENT [ ] OP clear [ ] Dentures [ ] Dentition (Good/Poor)

C-Spine [ ]FROM [ ] Limited F/E

Chest/CV[ ] CTAB [ ] Wheezing [ ] Murmur

ABD

L-Spine [ ] FROM [ ] Limited F/E

Hip

	Right	Left
Incisions		
F/E		
AB/AD		
ER/IR		
Obligate ER?		
Stinchfield/Roll		
GT TTP		

Knee

	Right	Left
Incisions		
Alignment	Varus / Valgus	Varus / Valgus
Effusion	Y / N	Y / N
PF Crepitus	Y / N	Y / N
Grind/Inhibition	Y / N	Y / N
ROM		
Pseudolaxity	M / L	M / L
Lach/PD		
Full Flex MT Signs	Y / N	Y / N
Mc Murray	Y / N	Y / N
JLTP	M / L	M / L

NVE

	Right	Left
Motor/Sensory		
Pulses	DP/PT	DP/PT

Radiologic Studies

[ ] AP Pelvis/hip [ ] WNL [ ] DJD (R/L/B) [ ] Fracture
[ ] ON [ ] Prior THA (well fixed Y/N)

[ ] Knees (3V) [ ] WNL [ ] DJD (R/L/B) [ ] Fracture
[ ] Prior TKA (well fixed Y/N)

[ ] MRI ___/___/___ _____

[ ] CT Scan ___/___/___ _____

AP

Hip/ Knee DJD	PT/IAJ	THA		TKA
Failed THA/TKA	AspirationCBC/ESR/CRP	CT	revTHA/TKA	
Infected THA/TKA	AspirationCBC/ESR/CRP	CT	2 stage TX plan	

DOB:
DOS:
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FIN:
MRN:

1012

REFERRING OR PRIMARY PHYSICIAN INFORMATION (So that we may mail a copy of your visit):

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

WORK COMP INFO (Please skip this section if not work related):

W/C Carrier: _____

W/C Claims Address: _____

City, State, Zip: _____

Claims Adjuster: _____

Phone Number: _____

Fax Number: _____

Employer: _____

Phone Number: _____

Address: _____

Claim #: _____

Date of Injury: _____

Nurse Case Manager: _____

Phone Number: _____

Fax Number: _____

ATTORNEY INFO:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Primary Treating Physician: _____

Address: _____

City, State, Zip: _____

Secondary Treating Physician: _____

Address: _____

City, State, Zip: _____

☐ Consultation Only ☐ 2nd Opinion Only ☐ Evaluation/Treatment

AUTHORIZED TO TREAT: ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Other: _____

☐ INFORMED TO BRING FILMS ☐ INFORMED TO BRING INTERPRETER

USC ORTHOPAEDIC SURGERY
SURGERY INTAKE FORM

PATIENT ID

DOB:
DOS:
ATT:
FIN:
MRN: