ROPER ST. FRANCIS
PHYSICIAN PARTNERS

(ecw letters: chkr2)

Patient History

Name: _____ Date: _____

Referring MD: _____ Primary MD_____

CHIEF COMPLAINT (circle the main reason for today's visit): Right hip Left hip
Right knee Left knee
Other

HISTORY OF PRESENT ILLNESS (circle choices or fill in blanks)

The main problem is: pain, stiffness, swelling, instability, difficulty walking, other _____

When did, the injury occur or problem start? _____

Pain Severity: none, mild, moderate, severe

When does it bother you most? Walking, stairs, lying down, other _____

Does this limit activities? Walking, stairs, exercise, work, housework, sleeping, donning socks/shoes, other _____

Does this cause falls or make you nervous about falling or your safety? Yes No

Any prior surgery in the involved area? Yes No

Have you seen an orthopaedist for current problems? Yes

Do you smoke? Yes No

Circle any you have tried for this: medication, weight loss, physical therapy injection(s), brace, shoe inserts, walker, cane, crutch

FAMILY MEDICAL HISTORY (Any blood relatives with arthritis or osteoporosis?):

PLEASE LIST DRUG ALLERGIES or [ ] No Known Drug Allergies:

PAST MEDICAL HISTORY (Please check below all that apply)

_____ High blood pressure
_____ Diabetes
_____ Pacemaker/Defibrillator
_____ Cancer besides minor skin
_____ Parkinson's Disease
_____ Alzheimer's Disease
_____ Schizophrenia
_____ Bipolar

CHARLESTON HIP & KNEE REPLACEMENT CENTER
Patient History

Name: _____

REVIEW OF SYMPTOMS (Please check below all that apply)

_____ Recent Fever
_____ Unexplained weight loss
_____ Rash, dermatitis, eczema
_____ Psoriasis
_____ Poor or slow healing
_____ Metal allergy (jewelry irritate skin?)
_____ Active dental problems
_____ Thyroid problems
_____ Shortness of breath
_____ Sleep Apnea
_____ Tuberculosis or TB Exposure
_____Circulatory problems
_____Previous heart problems or stent
_____History of blood clot/DVT/PE
_____Ulcers
_____Hepatitis/liver problems
_____HIV or AIDS

_____ Bleeding tendency
_____ Burning with urination
_____ Kidney Problems
_____ Fibromyalgia
_____ Chronic or intermittent back pain
_____ Osteoporosis
_____ Gout
_____ Weakness
_____ Numbness
_____ Stroke or mini stroke
_____ Balance problems
_____Depression
_____Severe Anxiety
_____Substance abuse / alcoholism
_____Anesthesia problems
_____Infection after surgery
_____Current or Recent Infection

Other health issues not listed above:

PRIOR SURGERIES (type of surgery and year):

PLEASE PROVIDE LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING: