

CHARLESTON HIP & KNEE REPLACEMENT CENTER

Patient History

Name: _____ Date: _____

Referring MD: _____ Primary MD _____

CHIEF COMPLAINT (circle the main reason for today's visit):

Right hip Left hip Other _____
Right Knee Left knee

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 problem? Yes No

Circle any you have tried for this: medications, 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)

- | | |
|----------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Cancer besides minor skin | <input type="checkbox"/> Bipolar |

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REVIEW OF SYSTEMS (Please check below all that apply)

- | | |
|-----------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Recent Fever | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Burning with urination |
| <input type="checkbox"/> Rash, dermatitis, eczema | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Poor or slow healing | <input type="checkbox"/> Chronic or intermittent back pain |
| <input type="checkbox"/> Metal allergy (jewelry irritate skin?) | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Active dental problems | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Stroke or mini stroke |
| <input type="checkbox"/> Tuberculosis or TB exposure | <input type="checkbox"/> Balance problems |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Previous heart problems or stent | <input type="checkbox"/> Severe Anxiety |
| <input type="checkbox"/> History of blood clot/DVT/PE | <input type="checkbox"/> Substance abuse / alcoholism |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Anesthesia problems |
| <input type="checkbox"/> Hepatitis/liver problem | <input type="checkbox"/> Infection after surgery |
| <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> 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: