

# Hartzband Center for Hip and Knee Replacement

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE OF VISIT \_\_\_\_/\_\_\_\_/\_\_\_\_

AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ OCCUPATION \_\_\_\_\_

**Who sent you to see us?** Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State: \_\_\_\_\_  
 Phone #: \_\_\_\_\_

**Where is your pain located?** (Circle all that apply) Groin Thigh Hip Buttocks Knee

**Which side?** Right / Left / Both **How long have you had pain?** \_\_\_\_\_

**How far can you walk before stopping?** \_\_\_\_\_ **Do you use?** Cane / crutches / walker / wheelchair

**Does the pain wake you at night?** No / Yes

**Have you had Physical Therapy?** No / Yes **Did it help?** No / Yes

**Have you had injections?** No / Yes **What type?** Cortisone Synvisc Hyalgan

**Have you had surgery for this?** No / Yes Describe \_\_\_\_\_

**What medicines have you taken for pain?** Tylenol / Motrin / Ibuprofen / Aleve / Advil / Celebrex / Tramadol / Mobic / Glucosamine / Chondroitin / Other? \_\_\_\_\_

**PAST MEDICAL HISTORY** (Have you ever had the following: (Circle no or yes, leave blank if uncertain))

High/low blood pressure	<i>no</i>	<i>yes</i>	Blood transfusions	<i>no</i>	<i>yes</i>
High Cholesterol	<i>no</i>	<i>yes</i>	Hepatitis	<i>no</i>	<i>yes</i>
Heart disease	<i>no</i>	<i>yes</i>	AIDS or HIV+	<i>no</i>	<i>yes</i>
Heart attack	<i>no</i>	<i>yes</i>	Dental disease	<i>no</i>	<i>yes</i>
Arrhythmia	<i>no</i>	<i>yes</i>	Tuberculosis	<i>no</i>	<i>yes</i>
Heart failure	<i>no</i>	<i>yes</i>	Bladder infections	<i>no</i>	<i>yes</i>
Diabetes	<i>no</i>	<i>yes</i>	Stomach ulcer	<i>no</i>	<i>yes</i>
Arthritis	<i>no</i>	<i>yes</i>	Mitral valve prolapse	<i>no</i>	<i>yes</i>
Anemia	<i>no</i>	<i>yes</i>	Kidney disease	<i>no</i>	<i>yes</i>
Cancer	<i>no</i>	<i>yes</i>	Thyroid disease	<i>no</i>	<i>yes</i>
Blood Clots	<i>no</i>	<i>yes</i>			
Asthma	<i>no</i>	<i>yes</i>			
Stroke	<i>no</i>	<i>yes</i>			
Chronic lung disease	<i>no</i>	<i>yes</i>			

Any other Disease: (Please list) \_\_\_\_\_

**PREVIOUS SURGERY**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all **MEDICINES** you are currently taking:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES** (Drugs, Iodine)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Marital Status:** Married / Single / Divorced / Widowed

**Do you drink alcohol?** no yes  
type & amount per week \_\_\_\_\_

**Do you smoke cigarettes?** no yes  
if yes, # packs per day \_\_\_\_\_

**Street drugs?** (type & amount per day) \_\_\_\_\_

**FAMILY HISTORY**

Has any blood relative had any of the following: (Circle no or yes, leave blank if uncertain)

Relationship			Relationship		
Arthritis	no	yes _____	Asthma	no	yes _____
Cancer	no	yes _____	Chronic lung disease	no	yes _____
Diabetes	no	yes _____	Depression	no	yes _____
Heart disease	no	yes _____	Blood Clot	no	yes _____
Stroke	no	yes _____	Thyroid disease	no	yes _____
Ulcer	no	yes _____	Kidney Disease	no	yes _____
Bleeding tendency	no	yes _____	Gout	no	yes _____

**Review of Symptoms: Do you have now or have you had within the past year?**

Persistent fever	never	occasionally	often	Blood in urine	never	occasionally	often
Weight change	never	occasionally	often	Heartburn	never	occasionally	often
Night sweats	never	occasionally	often	Nausea	never	occasionally	often
Blurred vision	never	occasionally	often	Vomiting	never	occasionally	often
Hearing loss	never	occasionally	often	Chronic diarrhea	never	occasionally	often
Frequent nose bleeds	never	occasionally	often	Rectal bleeding	never	occasionally	often
Sinus problems	never	occasionally	often	Joint pain or stiffness	never	occasionally	often
Chest pain or discomfort	never	occasionally	often	Skin rash	never	occasionally	often
Palpitations (Heart flutter)	never	occasionally	often	Skin problems	never	occasionally	often
Enlarged veins	never	occasionally	often	Headaches	never	occasionally	often
Swelling of feet or ankle	never	occasionally	often	Dizziness	never	occasionally	often
Difficulty breathing	never	occasionally	often	Seizures	never	occasionally	often
Wheezing	never	occasionally	often	Depression	never	occasionally	often
Chronic cough	never	occasionally	often	Memory loss	never	occasionally	often
Bloody sputum	never	occasionally	often	Easy bleeding	never	occasionally	often
Urinary difficulty	never	occasionally	often	Easy bruising	never	occasionally	often

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_