UNIVERSITY of CALIFORNIA • IRVINE
HEALTHCARE

CENTER FOR JOINT REPLACEMENT SURGERY
NEW PATIENT FORM

HISTORY

Welcome and thank you for choosing the UC Irvine Center for Joint Replacement Surgery for your care. Please take the time to answer all questions that apply to your problems as completely as possible.

Visit Date (mm/dd/yy): ____/____/____ Name (Last, First): _____

Date of birth (mm/dd/yy): ____/____/____ Age: _____ Sex: ☐ Male ☐ Female

Who referred you to this office?

☐ Referring Doctor: _____ Address: _____ Phone: _____

☐ Primary Physician: _____ Address: _____ Phone: _____

☐ Self Referral

A. Symptoms & Pain Assessment

1. Chief Complaint: _____

2. How long have you had these symptoms? _____ Days _____ Weeks _____ Months _____ Years

3. Describe the quality of your symptoms (Please check ✓ in the box):
   ☐ Pain ☐ Weakness ☐ Deformity ☐ Instability ☐ Abnormal motion ☐ Abnormal sensation
   ☐ Mass ☐ Swelling ☐ Other _____

4. How often do you experience these symptoms?
   ☐ Constant ☐ Intermittent ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

5. How did your symptoms start? ☐ Gradually ☐ Suddenly
   What date did your symptoms start? _____

6. Was there any injury/event that caused your symptoms?
   ☐ No ☐ Yes - Date of Injury (mm/dd/yy): ____/____/____
   Please describe how you were injured: _____
   _____

   a. Legal actions pending? ☐ No ☐ Yes
   b. Work related?
      ☐ No
      ☐ Yes - Employer at time of injury: _____
      Job Title: _____
      Worker's Compensation? ☐ No ☐ Yes - Name of your attorney: _____

9. Any prior lower extremity injury/pain before the event above?
   ☐ No ☐ Yes - What type? (Please describe) _____

10. Since your symptoms started, have they been getting: ☐ Better ☐ Worse ☐ Staying the same

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

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11. What makes your symptoms better? (Please describe)

_____

_____

12. What makes your symptoms worse? (Please describe)

_____

_____

13. Is there anything that restricts you from doing activities you want to do? ☐ Yes ☐ No

14. Is your quality of life affected? ☐ Yes ☐ No

B. Previous Treatment & Evaluation

1. What diagnostic tests have you had for this problem?
   ☐ X-ray ☐ MRI ☐ CT ☐ EMG/NCS ☐ Blood tests ☐ MR Arthrogram ☐ Other _____

2. Please check ✓ any of the following you have tried for your symptom or discomfort:
   ☐ Surgery ☐ Steroid injections ☐ Physical therapy ☐ Massage ☐ Splinting
   ☐ Intra-articular supplement injection
   ☐ Anti-inflammatory medications ☐ Other _____

   Which treatment has been the **best** treatment?

   _____

C. Medical/Surgical History

1. Please list other medical problems (Please check ✓ in the box):
   ☐ High blood pressure ☐ Arthritis ☐ Diabetes ☐ Heart disease - type:
   ☐ Stroke ☐ Osteoporosis ☐ High Cholesterol ☐ Cancer - type:
   ☐ Thyroid ☐ Asthma ☐ Stomach Ulcer ☐ Kidney stones
   ☐ Blood clots in leg ☐ Blood clots in lungs ☐ Depression ☐ AIDS/HIV
   ☐ Other
   a. Are you under the care of a Cardiologst? ☐ Yes ☐ No
      Name of Cardiologist: _____ Address/Location: _____
   b. Have you ever had problems with anesthesia? ☐ Yes ☐ No
      If yes, please explain: _____

2. Have you ever had **lower extremity surgery** in the past?
   ☐ No
   ☐ Yes - Type of surgery:
   _____ Date: _____
   _____ Date: _____
   _____ Date: _____

3. Please list other surgeries:

_____ Date: _____
_____ Date: _____
_____ Date: _____

D. Family Medical History (Please check ✓ in the box):

☐ Arthritis ☐ Bone Disease ☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Rheumatoid Arthritis ☐ Gout

Mother	Age: _____	☐ Healthy	☐ Deceased due to: _____
Father	Age: _____	☐ Healthy	☐ Deceased due to: _____
Brother/Sister	Age: _____	☐ Healthy	☐ Deceased due to: _____
	Age: _____	☐ Healthy	☐ Deceased due to: _____

E. Social History (Please check ✓ in the box):

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you have children? ☐ No ☐ Yes How many? _____

Do you live alone? ☐ Yes ☐ No Who lives with you? _____

Do you drink alcohol? ☐ No ☐ Yes If Yes, how much? _____

Do you smoke? ☐ No ☐ Yes ☐ Cigars/Pipe If Yes, how much? _____

Do you use recreational substances? ☐ No ☐ Yes If Yes, Type and Frequency: _____

Do you keep a special diet? ☐ No ☐ Yes ☐ Vegetarian ☐ Vegan ☐ Other _____

Have you lost or gained more than 10 pounds in the past 3 months? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No What exercise do you do? _____
How often? _____
How long is each session? _____

Are you currently working?

☐ No

☐ Yes - Employer: _____ Job Title: _____
Length of time on job: hours/day days/week
Movements required for your job (Please check ✓ in the box):
☐ twisting ☐ pushing ☐ sitting ☐ standing ☐ stopping ☐ crawling ☐ bending ☐ crouching
☐ grasping ☐ balancing ☐ squatting ☐ kneeling ☐ climbing stair ☐ climbing ladders
☐ lifting _____ pounds ☐ reaching above shoulders ☐ repeated wrist/hand movements
Sitting time _____ hours/day Standing time: _____ hours/day
Machines used: _____

Are you able to perform your usual duties? ☐ No ☐ Yes

F. Review of Systems

(Please check ✓ in the box if you **currently** have any problems related to the following systems):

Skin
- ☐ Skin rash
- ☐ Easy bruising/bleeding
- ☐ Abnormal hair loss
- ☐ Paralysis

Neurological
- ☐ Headache
- ☐ Migraine
- ☐ Seizure
- ☐ Glasses/Contacts

Eyes
- ☐ Visual loss
- ☐ Double vision
- ☐ Glaucoma

Bone/Joint/Muscles
- ☐ Muscle wasting
- ☐ Muscle cramping
- ☐ Joint pain

Ears/Nose
- ☐ Deafness
- ☐ Hoarseness
- ☐ Vertigo/dizziness
- ☐ Sinusitis

Genitourinary
- ☐ Blood in urine
- ☐ Impotence
- ☐ Painful urination
- ☐ Kidney stones
- ☐ Incontinence

Mental Status
- ☐ Hallucination
- ☐ Nervous breakdown
- ☐ Depression
- ☐ Sleep disturbance
- ☐ Suicidal thoughts

Respiratory
- ☐ Shortness of breath
- ☐ Asthma/Bronchitis
- ☐ Cough
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Emphysema / COPD

Gastrointestinal
- ☐ Appetite changes
- ☐ Jaundice
- ☐ Irritable bowels
- ☐ Nausea/Vomiting

Endocrine
- ☐ Goiter
- ☐ Heat/Cold intolerance
- ☐ Increased thirst

Cardiovascular
- ☐ Palpitations
- ☐ Chest pains
- ☐ Leg swelling
- ☐ Arrhythmia

Constitutional
- ☐ Fever/chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue

Blood System
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Bruising

MEDICATION

1. Do you have any Allergies to Medications, Food or Latex?

☐ No Known Allergies

☐ Yes - Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

2. Current Medications / Herbal / Natural Medications:

☐ None

☐ Yes, listed below:

Medications	Dose	Route	Frequency	Time & Date Last Taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				

PAIN SCALE

How severe is your pain today?

(Please circle the number to indicate how bad you feel your pain is today)

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Pain Rating

Please rate your **Average** level of pain on the following scale (circle one)

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Please rate your **Worst** level of pain on the following scale (circle one)

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Please rate your **Best** level of pain on the following scale (circle one)

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Patient Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____