

**CENTER FOR JOINT
REPLACEMENT SURGERY
NEW PATIENT FORM**

Patient Name: _____

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 Cardiologist? 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: _____

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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 If Yes, how much? _____
 Cigars/Pipe

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: _____

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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:

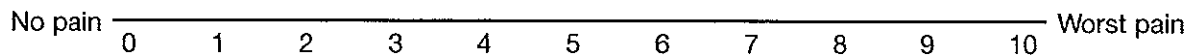
- None
 Yes, listed below:

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

PAIN SCALE

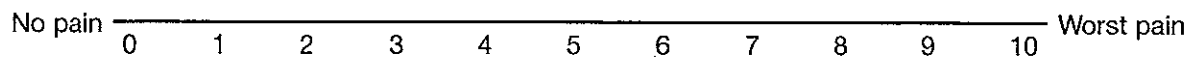
How severe is your pain today?

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

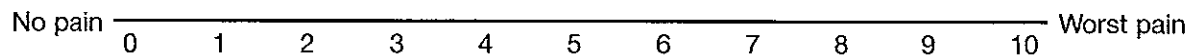


Pain Rating

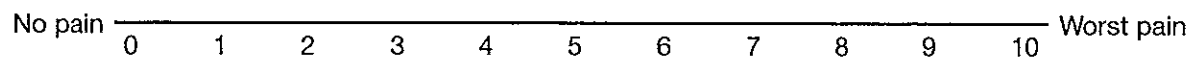
Please rate your **Average** level of pain on the following scale (circle one)



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



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



Patient Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____