

Richard A. Berger , MD
Joint Replacement and Orthopaedic Surgery

Name: _____ Date of Birth: _____ Date: _____

Who sent you to see us?

Name: _____
Address: _____
City, State: Zip: _____
Phone #: _____

Why are you seeing the doctor today? _____

Where is your pain?

- Right Hip Right Knee Back Left Hip Left Knee

How long have you had this problem? _____

If you are having **HIP PAIN**, where is it located?

- Groin Thigh Down below knee
 Side of Hip Down to knee Down to foot

If you are having **KNEE PAIN**, where is it located?

- Inside of the knee (close to the other knee) Front of knee (under kneecap)
 Outside of knee (away from the other knee) Back of knee

Is your pain: Getting Worse Getting Better Staying the same

Is your pain: Intermittent Constant

How would you describe your pain?

- Sharp Throbbing Burning Dull Tight Tingling

Do you have pain when you?

- Walk Sit Stand At Night

Is your pain worse when you?

- Stand At night Stand At night

Rate your pain on a scale from 1-10 (1 = minimal pain, 10=severe pain): _____

Do you have any of the following:

- Stiffness Numbness
 Swelling Weakness

Do you have a limp?

- None Moderate
 Slight Severe

How far are you able to walk before you begin to experience pain?

- Unlimited 2-3 blocks bed to chair only
 4-6 blocks Indoors only Unable to walk

How many stairs do you walk up **to get into** your home? _____

How many stairs must you walk up **inside** your home? _____

Name: _____

Do you need assistance with walking?

- None Cane all of the time Walker
 Cane, long walks only Wheelchair

Do you have difficulty going up or down stairs?

- None Take one step at a time
 Use banister always Use crutches or cannot do stairs

Do you have difficulty putting on your shoes and socks?

- None Unable With difficulty

Can you sit in a chair comfortably?

- Any chair for more than 1 hour Unable to sit for 1/2 hour
 High chair for 1/2 hour

Can you get up from a chair:

- Normally Difficulty even when using my arms
 Need help Unable to do alone

Have you tried any of the following medications?

- Tylenol Aspirin Vioxx Celebrex
 Motrin Alleve Other _____

Have you tried injections? Yes No

What kind of injections? Steroids Synvisc Don't know

How many injections? _____

Have you tried physical therapy/exercises? Yes No

PAST MEDICAL HISTORY

Please list all of your medical problems (such as high blood pressure or heart disease):

Please list all of your past surgeries/hospitalizations/severe injuries with dates
(month/year)

OTHER INFORMATION

Height : _____ Weight : _____

Name: _____

Do you have allergies to any medications? _____
If yes, what is your reaction? _____

What local pharmacy do you use? _____ Phone: _____

What medications do you presently take (include name and dose):

Do you have a latex allergy? Yes No
If yes, what reaction? _____

SOCIAL HISTORY

What kind of work do you do?
 Homemaker Manual labor Retired Desk Job
 On disability Occupation: _____

Marital Status: Single Married Divorced Widowed
Spouse's Occupation: _____

Do you have children? Yes No How many children? _____
Who lives at home with you? _____
Who will assist you after your surgical procedure? _____

Do you drink alcohol? Yes No If yes, # drinks per week: _____
Do you use illicit drugs? Yes No Describe: _____
Do you smoke? Yes No If yes, # packs per day: _____ For how many years? _____

Do you exercise regularly? Yes No How many times per week? _____
Do you follow a special diet? Yes No What kind? _____

FAMILY HISTORY

Member	Alive/Deceased	Age/Health Status	Cause of death
Father			
Mother			
Sibling			
Sibling			
Sibling			

Name: _____

Do you currently or have you ever had problems with any of the following that you did NOT list elsewhere?

Constitutional Musculoskeletal

- Recent weight loss Yes No
- Rheumatoid Arthritis Yes No
- Recent fevers Yes No
- Ankylosing Spondylitis Yes No
- Lupus Yes No
- Osteoporosis Yes No
- Paget's Disease Yes No

Eyes

- Wear glasses Yes No
- Cataracts Yes No
- Glaucoma Yes No

Skin

- Psoriasis Yes No
- Eczema Yes No
- Dermatitis Yes No

Ears, nose, throat, mouth

- Sinus problems Yes No
- Active dental problem Yes No

Neurologic

- Seizures/Epilepsy Yes No
- Alzheimer's Disease Yes No
- Polio Yes No
- Parkinson's Disease Yes No
- Balance problems Yes No

Cardiovascular

- Heart attack Yes No
- Heart murmur Yes No
- Irregular heart beat Yes No
- High blood pressure Yes No
- High cholesterol Yes No
- Valve problem Yes No

Psychiatric

- Depression Yes No
- Schizophrenia Yes No
- Anxiety Yes No

Respiratory

- Asthma Yes No
- Bronchitis Yes No
- Emphysema Yes No
- Tuberculosis Yes No
- Pneumonia Yes No

Endocrine

- Diabetes Yes No
- Thyroid Yes No

Hematologic/Blood

- Blood Clots Yes No
- Anemia Yes No

Gastrointestinal

- Colitis Yes No
- Diverticulitis Yes No
- Ulcer Yes No

Genitourinary

- Prostate problem Yes No
- Kidney problem Yes No
- Bladder infections Yes No

Cancer

- Yes No
- What kind? _____

- Hernia Yes No
- What kind? _____

- Hepatitis/ liver problem Yes No