EMORY
ORTHOPAEDICS &
SPINE CENTER

PATIENT INFORMATION SHEET

BACKGROUND

Name: _____ Date: _____

Age: _____ Ht: _____ Wt: _____ □ MALE □ FEMALE

Hobbies/Sports/Exercise Activities: _____

Who Referred You?: _____ ❑ MD ❑ Friend ❑ Patient

If referred by MD, include address & phone number: _____

Physicians who follow you regularly (PCP, cardiologist, etc.): _____

_____

ALLERGIES (Please list any known drug allergies)

_____

_____

_____

_____

_____

CURRENT MEDICATIONS (List name & dose of medication):

_____

_____

_____

_____

_____

PREFERRED PHARMACY _____

Phone Number (_____)_____-_____

SOCIAL HISTORY

Occupation: _____ ❑ Full Time ❑ Part Time ❑ Student

If not working, are you: ❑ Retired ❑ On Disability ❑ Unemployed

Do you smoke? □ Yes □ Never □ Former – Year Quit_____ If yes, how many packs per day? _____

Do you drink alcohol? □ Yes – how much? _____ □ No

Have you ever had a problem with drug dependence? □ Yes □ No

Marital status: □ Married □ Single □ Divorced □ Widowed

Are you pregnant: ❑ YES ❑ NO Children: □ Yes □ No How many? ____

Who lives with you?: _____

SURGICAL HISTORY: (List any past surgeries, including the month/year of surgery)

❑ Appendectomy	_____	❑ Knee Arthroscopy	_____
❑ Tonsillectomy	_____	❑ Total Knee Replacement	_____
❑ Hernia Repair	_____	❑ Total Hip Replacement	_____
❑ Gallbladder	_____	❑ _____	
❑ Hysterectomy	_____	❑ _____	
❑ _____		❑ _____	

Have you ever had a surgical infection? ❑ YES ❑ NO (If yes, where? _____)

Have you ever had general anesthesia? ❑ YES ❑ NO

Any Problems with Anesthesia? ❑ YES ❑ NO (Problem: _____)

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REASON FOR VISIT:

_____

_____

		No Pain ☺					☹				Severe Pain
What Hurts?	❑ Right Hip	0	1	2	3	4	5	6	7	8	9	10
	❑ Left Hip	0	1	2	3	4	5	6	7	8	9	10
	❑ Right Knee	0	1	2	3	4	5	6	7	8	9	10
	❑ Left Knee	0	1	2	3	4	5	6	7	8	9	10
	❑ Spine	0	1	2	3	4	5	6	7	8	9	10
	❑ _____	0	1	2	3	4	5	6	7	8	9	10

How long have you had this pain? (Months, Years) _____

Was this the result of an injury? ❑ YES ❑ NO If Yes, Date of Injury: _____

Lawsuit Pending: ❑ YES ❑ NO Workers' Compensation: ❑ YES ❑ NO

What makes the pain better? _____

What makes the pain worse? _____

Do you use any of the following:
❑ Cane ❑ Crutches ❑ Walker ❑ Wheelchair

How do you walk stairs?
❑ One leg after the other (normal)
❑ Lead with same leg each time

Do you need a rail to walk up/down stairs? ❑ YES ❑ NO

How far can you walk before limited by pain: _____

What have you tried to help the pain?

- ❑ Ice
- ❑ Rest/Decreased activity
- ❑ Physical Therapy
- ❑ Pain Medication: ❑Percocet ❑Vicodin ❑Lortab ❑Oxycodone ❑OxyContin
- ❑ Anti-inflammatory: ❑Vioxx ❑Celebrex ❑Bextra ❑Aspirin
  ❑Ibuprofen ❑Motrin ❑Advil ❑Alleve ❑Naprosyn
- ❑ Glucosamine/Chondroitin Sulfate
- ❑ Injections
  - ❑ Hip ❑ Knee ❑ Spine
  - When was your last injection? _____
  - How long did your injection last? ❑___Days ❑___Weeks ❑___Months ❑___Years
  - How many total injections have you had? _____
- ❑ Orthotics
- ❑ Acupuncture
- ❑ Chiropractor
- ❑ Cane
- ❑ Brace ❑ Other _____

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PAST MEDICAL HISTORY: (Please choose all current and past medical conditions)

□ No medical problems
□ High blood pressure
□ Heart attack
□ Heart failure
□ Abnormal heart rhythm
□ Lung disease
□ Tuberculosis
□ Asthma
□ Bronchitis
□ Emphysema
□ Hepatitis
□ Liver disease
□ Thyroid disease
□ Diabetes
□ Irritable bowel
□ Stomach ulcers
□ Stroke
□ Seizures
□ Kidney failure
□ Endometriosis
□ Ovarian cysts
□ Kidney stones
□ Osteoporosis
□ Osteoarthritis
□ Rheumatoid arthritis
□ Bleeding disorders
□ Anemia
□ Blood clots in legs/lungs
□ HIV
□ Alcoholism
□ Anxiety
□ Depression
□ Schizophrenia
□ Anorexia/bulemia

FAMILY HISTORY: (Indicate conditions that run in your close family)

Condition	*Relationship*	*Condition*	*Relationship*
□ Arthritis	_____	□ Cancer: Type: _____	_____
□ Heart disease	_____	□ Thyroid Disease:	_____
□ High Blood Pressure	_____	□ Anesthesia Complications:	_____
□ Diabetes	_____	□ Alcoholism:	_____
□ Bleeding Disorder	_____	□ Other:	_____

REVIEW OF SYSTEMS: (Have you experienced any of the following *recently*)

General
□ Unexplained weight loss
□ Appetite change
□ Fevers or chills
□ Night sweats
□ Marked fatigue
□ Difficulty sleeping

Ear, Eyes, Nose, Throat
□ Difficulty swallowing
□ Hoarseness
□ Loss of hearing
□ Ear pain
□ Nosebleeds
□ Gum trouble
□ Change of vision

Cardiovascular
□ Heart or chest pain
□ Abnormal heartbeat
□ Poor heart function

Digestive
□ Nausea or vomiting
□ Stomach pain or ulcers
□ Heartburn/acid
□ Frequent diarrhea
□ Frequent constipation
□ Uncontrolled loss of stool
□ Blood in stool
□ Hemorrhoids

Skin
□ Rashes
□ Frequent itchiness
□ Easy bruising
□ Swollen ankles

Neurological
□ Seizures
□ Blackouts/fainting
□ Tremors
□ Headaches/migraines

Psychiatric
□ Depression
□ Nervous exhaustion
□ Anxiety
□ Paranoia
□ Obsessive/compulsive behavior

Genitourinary
□ Burning on urination
□ Difficulty starting urination
□ Incontinence
□ Pelvic pain
□ Urinate at night more than once

Lung
□ Cough
□ Shortness of breath
□ Productive cough or sputum