EMORY
ORTHOPAEDICS &
SPINE CENTER

PATIENT INFORMATION SHEET

BACKGROUND

Name: _____ Date: _____

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

Hobbies/Sports/Exercise Activities: _____

Who Referred You?: _____ ❑ MD ❑ Frien d ❑ 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):

_____

_____

_____

_____

_____

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: _____)

Have you ever had radiation or chemotherapy? ❑ YES ❑ NO (If yes, what kind? _____)

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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

REASON FOR VISIT:

_____

_____

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How is your pain level today? (Circle) No Pain Severe Pain
0 1 2 3 4 5 6 7 8 9 10

Are you taking anything for you pain? _____

Are you being evaluated for a KNEE or HIP replacement? ❑ YES ❑ NO
If YES, continue appropriate section below:

KNEE (Check all that apply)

How much pain do you have when walking?
□ None □ Mild/Occasional □ Moderate □ Severe

How much pain does your knee cause when going up and down stairs?
□ None □ Mild/Occasional □ Moderate □ Severe

How much pain does your knee cause when you are at rest?
□ None □ Mild/Occasional □ Moderate □ Severe

How does your knee affect your walking ability? I can walk:
□ Unlimited □ 11-20 blocks □ 5-10 blocks □ 1-4 blocks
□ Less than 1 block □ Cannot walk at all

How do you go up stairs?
□ Go up the stairs normally □ Use the hand rail for balance
□ Use the handrail to pull myself up □ Cannot climb stairs

How do you go down stairs?
□ Go down the stairs normally □ Use the hand rail for balance
□ Use the handrail to support myself □ Cannot go down stairs

How do you get out of a chair?
□ Get out of chair normally □ Use arm rests for balance
□ Use arm rests to push myself □ Cannot get out of a chair

What type of support do you use when walking?
□ None □ Cane □ 2 Canes □ Crutches □ Walker

HIP (Check all that apply)

Pain: □ None □ Slight □ Mild □Moderate □Severe □ Disabled
Limp: □None □ Slight □ Moderate □ Unable to walk
Usual support needed:
□ None □ Single cane for long walks □ Single cane most of the time
□ One crutch □ 2 canes □ Walker □ Unable to walk

I can walk: □ Unlimited □ 6 blocks □ 2-3 blocks □ Indoors only □ Unable to walk

How do you climb stairs?
□ Foot over foot without banister □ Foot over foot with banister
□ Any manner (one step at a time, crawl, etc.) □ Unable to climb stairs

Are you able to Enter Public Transportation: □ Yes □ No

Comfortable sitting in a chair for: □ 1 hour + □ ½ hour □ Unable to sit in a chair

I can put on my shoes and socks: □Easily □With difficulty □Need assistance