Patient Label

UC Irvine Health

CENTER FOR JOINT REPLACEMENT 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 complete as possible.

Name (Last, First)____ Visit date (mm/dd/yy):_____/_____/_____
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. How did your symptoms start? ☐ Gradually ☐ Suddenly
What date did your symptoms start?____

4. 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 the time of injury:______________________________
Job Title: ____
Worker's Compensation? ☐ No ☐ Yes - name of your attorney:_______________________________

5. Describe the quality of your symptoms (Please check √ in the box):
☐ Pain ☐ Weakness ☐ Deformity ☐ Instability ☐ Abnormal motion
☐ Abnormal Sensation ☐ Mass ☐ Swelling ☐ Other______________________________

6. How often do you experience these symptoms?
☐ Constant ☐ Intermittent ☐ Daily ☐ Weekly ☐ Monthly ☐ Other____________________

7. Any prior lower extremity injury/pain before the event above?
☐ No ☐ Yes – What type? (Please describe)____

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

9. What makes your symptoms better? (Please describe)_______________________________________
____

10. What makes your symptoms worse? (Please describe)_______________________________________
____

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

12. Has your quality of life been affected? ☐ Yes ☐ No

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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B. Pain Scale

Please rate your level of pain **today**

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

Please rate your **average** level of pain

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

Please rate your **worst** level of pain

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

Please rate your **best** level of pain

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

C. 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 symptoms or discomfort:

☐ Non-steroidal anti-inflammatory medications
☐ Massage
☐ Splinting
☐ Cane
☐ Walker
☐ Wheelchair
☐ Physical therapy
☐ Steroid injection
☐ Intra-articular supplement injection
☐ Surgery
☐ Other

a. Which treatment has been the **best** treatment?____

D. Medical/Surgical History

1. Please list other medical problems (Please check in the box):

☐ High blood pressure
☐ Stroke
☐ High cholesterol
☐ Heart disease – type:_______________
☐ Asthma
☐ Diabetes
☐ Arthritis
☐ Kidney Stones
☐ Osteoporosis
☐ Thyroid
☐ Stomach ulcer
☐ Blood clots in leg
☐ Blood clots in lungs
☐ HIV/AIDS
☐ UTI
☐ Cancer – type:_______________
☐ Depression

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:____________________

3. Please list other surgeries:

____ Date:____________________

____ Date:____________________

____ Date:____________________

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

☐ Osteoarthritis ☐ Bone disease ☐ Diabetes ☐ Blood clots
☐ Rheumatoid arthritis ☐ Heart disease ☐ Gout ☐ Cancer

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

F. 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? ☐ No ☐ Yes Who lives with you? ______________________

Do you live in a: ☐ House ☐ Apartment ☐ Other ______________________

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

Do you smoke/chew/vape? ☐ No ☐ Yes 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? ☐ No ☐ Yes What exercise do you do?______________________

How often?_____________ How long is each session?______________________

Are you currently working?

☐ No – Previous Job Title:______________________
☐ 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 ☐ Stooping ☐ Crawling ☐ Bending ☐ Crouching
☐ Grasping ☐ Balancing ☐ Squatting ☐ Kneeing ☐ Climbing ☐ Stairs ☐ Climbing Ladders Lifting________
Pounds/Reaching above Shoulders/Repeated Wrist/Hand Movements
Sitting Time:_______ hours/day Standing Time:_______ hours/day
Machines used:______________________

G. <u>MEDICATION</u>

1. Current Medications/Herbal/Natural Medications:

☐ None
☐ Yes, list below:

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

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2. Allergies, including drugs, food, metal/jewelry

☐ No Known Allergies

☐ Yes Allergy:__________________ Reaction:______________________________

Allergy:__________________ Reaction:______________________________

Allergy:__________________ Reaction:______________________________

Allergy:__________________ Reaction:______________________________

Allergy:__________________ Reaction:______________________________

H. REVIEW OF SYSTEMS (Mark all that apply)

Constitutational
- ☐ Fatigue
- ☐ Fever/chills
- ☐ Night sweats
- ☐ Weight loss
- ☐ Weight gain

Eyes
- ☐ Glasses/contacts
- ☐ Double vision
- ☐ Painful vision
- ☐ Glaucoma
- ☐ Visual changes

Ears/Nose/Throat
- ☐ Vertigo/dizziness
- ☐ Runny nose
- ☐ Nose bleeds
- ☐ Bleeding gums
- ☐ Toothache

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations/arrhythmia
- ☐ Leg swelling
- ☐ Claudication
- ☐ Shortness of breath

Respiratory
- ☐ Cough
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Pneumonia
- ☐ Tuberculosis

Gastrointestinal
- ☐ Abdominal pain
- ☐ Indigestion
- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation
- ☐ Bloody stools

Genitourinary
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Penile/vaginal discharge

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Muscle cramping
- ☐ Muscle wasting

Integumentary (Skin)
- ☐ Skin changes
- ☐ Skin rash
- ☐ Skin discoloration
- ☐ Cellulitis
- ☐ Sores/Wounds

Neurologic
- ☐ Headache
- ☐ Migraine
- ☐ Seizure
- ☐ Pins and needles
- ☐ Numbness

Psychiatric
- ☐ Depression
- ☐ Sleep disturbance
- ☐ Hallucination
- ☐ Nervous breakdown
- ☐ Suicidal thoughts

Endocrine
- ☐ Goiter
- ☐ Heat/cold intolerance
- ☐ Increased thirst
- ☐ Impotence

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

Signature ______________________________ **Date** ______________