CRAIG J. DELLA VALLE, MD

JOINT REPLACEMENT AND ORTHOPAEDIC SURGERY

Name: _____ Date of Birth:_____ Date:_____

Who is your referring doctor? Name:_____
(If none, list your primary doctor's info) 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:
❑ Walk ❑ Sit
❑ 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 can you walk *BEFORE* you start having 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?_____
How would you rate your hip/knee today as a percentage
of normal (0 to 100 scale with 100 being normal)? _____

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Do you need assistance with walking?
- ❑ None
- ❑ Cane, long walks only
- ❑ Cane all of the time
- ❑ Walker
- ❑ Wheelchair

Do you have difficulty going up or down stairs?
- ❑ None
- ❑ Use banister always
- ❑ Take one step at a time
- ❑ Use crutches or cannot do stairs

Do you have difficulty putting on your shoes and socks?
- ❑ None
- ❑ With difficulty
- ❑ Unable

Can you sit in a chair comfortably for:
- ❑ Any chair for more than 1 hr
- ❑ High chair for 1/2 hour
- ❑ Unable to sit for 1/2 hour

Can you get up from a chair:
- ❑ Normally
- ❑ Use my arms
- ❑ Difficulty even when using my arms
- ❑ Need help, unable to do alone

Have you tried any of the following medications?
- ❑ Tylenol
- ❑ Motrin
- ❑ Aspirin
- ❑ Alleve
- ❑ Vioxx
- ❑ Celebrex
- ❑ 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):

_____
_____
_____
_____
_____

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Do you have allergies to any medications? _____

Do you have any allergies or sensitivity to metals? _____

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

_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

What kind of work do you do?

❏ Homemaker ❏ Manual labor
❏ Retired ❏ Desk Job
❏ On disability ❏ Occupation: _____

Marital Status ❏ Single ❏ Married ❏ Divorced ❏ Widowed

Do you live alone? ❏ Yes ❏ No

If no, who lives at home with you? _____

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			

OTHER INFORMATION

Height :_____ Weight :_____

Reviewed by: _____ *Date:*_____

Name: _____

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

Constitutional
- Recent weight loss ❑ Yes ❑ No
- Recent fevers ❑ Yes ❑ No

Eyes
- Wear glasses ❑ Yes ❑ No
- Cataracts ❑ Yes ❑ No
- Glaucoma ❑ Yes ❑ No

Ears, nose, throat, mouth
- Sinus problems ❑ Yes ❑ No
- Active dental problem ❑ 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

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

Gastrointestinal
- Colitis ❑ Yes ❑ No
- Diverticulitis ❑ Yes ❑ No
- Ulcer ❑ Yes ❑ No
- Hernia ❑ Yes ❑ No
- Hepatitis or liver problem ❑ Yes ❑ No

Genitourinary
- Prostate problem ❑ Yes ❑ No
- Kidney problem ❑ Yes ❑ No
- Frequent bladder infections ❑ Yes ❑ No

Musculoskeletal
- Rheumatoid Arthritis ❑ Yes ❑ No
- Ankylosing Spondylitis ❑ Yes ❑ No
- Lupus ❑ Yes ❑ No
- Osteoporosis ❑ Yes ❑ No
- Paget's Disease ❑ Yes ❑ No

Skin
- Psoriasis ❑ Yes ❑ No
- Eczema ❑ Yes ❑ No
- Dermatitis ❑ Yes ❑ No

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

Psychiatric
- Depression ❑ Yes ❑ No
- Schizophrenia ❑ Yes ❑ No

Endocrine
- Diabetes ❑ Yes ❑ No
- Thyroid ❑ Yes ❑ No

Hematologic/Blood
- Blood Clots ❑ Yes ❑ No
- Anemia ❑ Yes ❑ No

Cancer
- What kind? _____ ❑ Yes ❑ No

OTHER _____
_____
_____
_____
_____

Reviewed by: _____ *Date:*_____