

CRAIG J. DELLA VALLE, MD
JOINT REPLACEMENT AND ORTHOPAEDIC SURGERY

Name: _____ Date of Birth: _____ Date: _____

Who is your referring doctor?
(If none, list your primary doctor's info)

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:

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?

- | | | |
|---|--|----------------------------------|
| <input type="radio"/> None | <input type="radio"/> Cane all of the time | <input type="radio"/> Wheelchair |
| <input type="radio"/> Cane, long walks only | <input type="radio"/> Walker | |

Do you have difficulty going up or down stairs?

- | | |
|---|--|
| <input type="radio"/> None | <input type="radio"/> Take one step at a time |
| <input type="radio"/> Use banister always | <input type="radio"/> Use crutches or cannot do stairs |

Do you have difficulty putting on your shoes and socks?

- | | |
|---------------------------------------|------------------------------|
| <input type="radio"/> None | <input type="radio"/> Unable |
| <input type="radio"/> With difficulty | |

Can you sit in a chair comfortably for:

- | | |
|--|--|
| <input type="radio"/> Any chair for more than 1 hr | <input type="radio"/> Unable to sit for 1/2 hour |
| <input type="radio"/> High chair for 1/2 hour | |

Can you get up from a chair:

- | | |
|-----------------------------------|--|
| <input type="radio"/> Normally | <input type="radio"/> Difficulty even when using my arms |
| <input type="radio"/> Use my arms | <input type="radio"/> Need help, unable to do alone |

Have you tried any of the following medications?

- | | | | |
|-------------------------------|-------------------------------|-----------------------------------|--------------------------------|
| <input type="radio"/> Tylenol | <input type="radio"/> Aspirin | <input type="radio"/> Vioxx | <input type="radio"/> Celebrex |
| <input type="radio"/> Motrin | <input type="radio"/> Alleve | <input type="radio"/> 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
- Retired
- On disability
- Manual labor
- Desk Job
- 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 : _____

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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

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Date: _____