Please complete the following questionnaire.

Your Care Team

Referring Provider

Name:

Address: | City:

State: | Zip Code:

Phone Number: | Fax Number:

Primary Care Provider

Name:

Address: | City:

State: | Zip Code:

Phone Number: | Fax Number:

Cardiology Provider (if applicable)

Name:

Address: | City:

State: | Zip Code:

Phone Number: | Fax Number:

Pharmacy

Name of Preferred Pharmacy

Address: | City:

State: | Zip Code:

Phone Number: | Fax Number:

Current Medications

Please include prescription, over the counter, samples, vitamins, herbal products, respiratory treatments, parenteral nutrition, supplements, and any other FDA substance listed as a drug.

Name of Medication	Dose	Frequency

Allergies	
Type	**Name and Reaction (rash, difficulty breathing, GI Upset)**
Medication	
Latex	
Other	

Health History Questionnaire

Height:________________________ **Weight:** ________________________

Where is your pain located? ________________________

Which side of your body? ________________________

How long have you had the pain? ________________________

How far can you walk comfortably? ________________________

Please circle your pain using the scale below, where 0 is “No Pain” and 10 is “Worst Pain”.

0 1 2 3 4 5 6 7 8 9 10

Other Symptoms: (Check all that apply)

☐ Limping	☐ Fatigue	☐ Grinding	☐ Swelling
☐ Weakness	☐ Falling	☐ Stiffness	☐ Clicking
☐ Locking	☐ Pain at night	☐ Buckling	☐ Low back Pain
☐ Leg Length Discrepancy	☐ Instability	☐ Guarding	☐ Other:

Are your symptoms worsened by: (Check all that apply)

☐ Walking	☐ Standing	☐ Stairs	☐ Hills
☐ Uneven ground	☐ Getting Dressed	☐ Work	☐ Exercise
☐ Sports	☐ Travel	☐ Cold Weather	☐ Twisting
☐ Pivoting	☐ Bending	☐ Getting into/out of a car	☐ Putting on shoes
☐ Crossing legs	☐ Sitting	☐ Other:	

How have you tried to manage your symptoms: (Check all that apply)

☐ NSAIDs	☐ Narcotics	☐ Physical Therapy	☐ Arthroscopy
☐ Tylenol	☐ Trainer	☐ Shoe Lift	☐ Time off Work
☐ Ice	☐ Weight Loss	☐ Glucosamine	☐ Chiropractor
☐ Acupuncture	☐ Topical Rubs	☐ CBD/THC	

Have you tried injection therapy: (Check all that apply)

☐ Steroids	☐ Viscosupplementation (Knee gel shots)	☐ PRP	☐ Stem Cell

Do you use assistive devices: (Check all that apply)

☐ Walker	☐ Wheelchair	☐ Brace	☐ Cane
☐ Crutches	☐ Other:		

Medical History

Do you have, or have you ever been treated for any of the following?
Please answer this section carefully and completely as this information will determine your surgical care plan. **(We know that this is a long list, but this information is important)**

General Information

☐ Cancer: Type:______________________Ongoing Treatment? ☐ Yes ☐ No

☐ Blood Thinner: Which One: ______________________	☐ Live Alone
☐ Blood Clot (DVT or PE): Where:___________________	☐ Stairs at Home
☐ AICD/Pacemaker: Manufacturer: _________________	☐ Are you in pain management?
☐ Spinal Stimulator: Manufacturer: _________________	☐ Are you on any weight-loss medications?

Cardiopulmonary

☐ Arrhythmia/Palpitations	☐ Congestive Heart Failure	☐ Cardiac Stents
☐ High Blood Pressure	☐ Heart Attack	☐ Heart Surgery
☐ High Cholesterol	☐ Coronary Artery Disease	☐ Aortic Stenosis
☐ Asthma	☐ COPD	☐ Sleep Apnea
		☐ Valve Replacement

Neurological

☐ Stroke	☐ Glaucoma	☐ Depression
☐ Seizures	☐ Loss of Hearing	☐ Anxiety
☐ Parkinson's Disease	☐ Migraine Headaches	☐ Fibromyalgia
☐ Alzheimer's	☐ Vertigo	☐ Chronic Pain
☐ Other Dementia	☐ Balance Problems	☐ Fainting

Gastrointestinal

☐ Diabetes	☐ Colitis	☐ Difficulty swallowing
☐ Prediabetes	☐ Gastric Bypass/Sleeve	☐ Cirrhosis of liver
☐ GI Bleed or Ulcers	☐ GERD	☐ Crohn's disease
☐ Constipation	☐ Motion Sickness	☐ Nausea (esp post-op)

Genitourinary

☐ Urinary Incontinence	☐ BPH (Enlarged Prostate)	☐ Kidney Disease

Hematology

☐ Anemia	☐ Leukemia	☐ Von Willebrand's
☐ Blood clotting disorder:	☐ Lymphoma	☐ Frequent Nose Bleeds
☐ Bleeding disorder:		

Musculoskeletal

☐ Osteopenia	☐ Scoliosis	☐ Ehlers's Danlos
☐ Arthritis in other joints	☐ Rheumatoid Arthritis	☐ Autoimmune disease

Infectious Diseases

☐ HIV	☐ History of Staph Infection	☐ History of *C. Diff*
☐ Hepatitis; type:_____________		

Orthopaedic History

Please include ***any musculoskeletal or joint-related*** surgeries or ***history of fractures***.

Procedure	Date	Surgeon

Surgical History

Please include any ***additional*** surgeries.

Procedure	Date	Surgeon

PATIENT ID

Advance Directive

Do you have an Advanced Directive? YES NO

Falls Screening

In the past 6 months…

have you worried about falling or felt unsteady? YES NO

have you had any near falls or falls? YES NO

have you had a fall related injury with symptoms lasting longer than 5 days? YES NO

External Facility Imaging Information

Please complete this information if you're bringing in external x-rays or MRIs to your visit.
X-Rays must be taken within the past 6 months to be evaluated. **CD Only, Report not needed.**
MRIs must be taken within a year. **CD and Report needed.**

X-RAY

Body Part: __________

Date Taken: __________

Name of Facility: __________

Address: __________

Phone Number: __________ Fax Number: __________

MRI

Body Part: __________

Date Taken: __________

Name of Facility: __________

Address: __________

Phone Number: __________ Fax Number: __________