Keck Medicine of USC

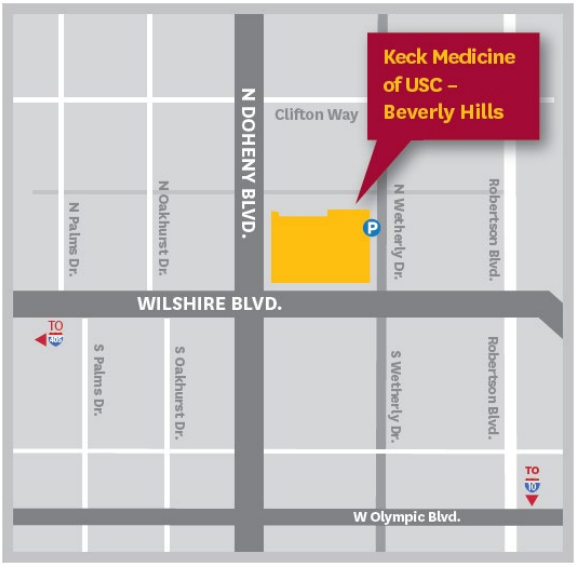
Orthopaedic Surgery
9033 Wilshire Blvd, Suite 360
Beverly Hills, CA 90211
Office: (310) 281-5010 | **Fax:** (310) 281-5011
web: keckmedicine.org/services/orthopedics
web: totaljoints.net

Dear Patient:

Welcome to Keck Medicine of USC - Beverly Hills, Orthopaedic Surgery. We thank you for choosing USC, a trusted leader in quality health care.

Please prepare for your appointment with the following:

- Submit completed intake forms 2 business days prior to your appointment.
- Bring applicable insurance card(s).
- Bring valid government issued picture identification.
- Bring images from an outside facility (if applicable).
- Wear comfortable and loose clothing.
- Underground parking is available for all patients and visitors. The entrance is off Wetherly Street, on the right side of the building. The fee is $2.50 every 15 minutes with a maximum of $22.50 per day. Only credit cards are accepted. Unfortunately, we do not validate at this time.



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Please complete the following questionnaire.

Patient Demographics

Name (First, Middle, Last):

Social Security Number: | Sex:

Birthdate: | Aliases:

Permanent Address

Address: | City:

State: | Zip Code:

Contact Information

Home Phone: | Work Phone:

Mobile Phone: | Email Address:

General Information

Language: | Marital Status:

Ethnicity: | Race:

Preferred Language: | Religion:

Employer Information

Employer:

Address: | City:

State: | Zip Code:

Employment Status: | Occupation:

Phone Number:

Emergency Contact

Name (First, Last): | Relationship to Patient:

Home Phone: | Work Phone:

Mobile Phone:

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	

External Facility Imaging Information

Please complete this information if you're bringing in external x-rays or MRIs to your visit. Images must be taken within the past 6 months to be evaluated.

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: _____

Report Included? ☐ Yes ☐ No

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:
- ☐ Blood Thinner: Which One:
- ☐ Blood Clot (DVT or PE): Where:
- ☐ AICD/Pacemaker: Manufacturer:

Ongoing Treatment? ☐ Yes ☐ No

- ☐ Live Alone
- ☐ Stairs at Home
- ☐ Are you in pain management?

Cardiopulmonary

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

Neuro

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

GI

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

GU

- ☐ Urinary Incontinence
- ☐ Benign Prostatic Hypertrophy
- ☐ Kidney Disease

Hematology

- ☐ Anemia
- ☐ Blood clotting disorder:
- ☐ Bleeding disorder:
- ☐ Osteoporosis
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Von Willebrand's
- ☐ Arthritis in other joints
- ☐ Frequent Nose Bleeds
- ☐ Autoimmune disease
- ☐ Rheumatoid Arthritis

Musculoskeletal

- ☐ Osteopenia
- ☐ HIV
- ☐ Scoliosis
- ☐ History of Staph Infection
- ☐ History of *C. dif.*

Infectious Diseases

- ☐ HIV
- ☐ History of Staph Infection
- ☐ History of *C. dif.*

Pain Assessment Questionnaire

To better understand your needs, we would like to know the types of thoughts and feelings that you have when you are in pain. Below are statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

Please only check one from each row:	**Not at all**	**To a slight degree**	**To a great degree**	**All the time**
I worry all the time about whether the pain will end.	☐	☐	☐	☐
I feel I can't go on.	☐	☐	☐	☐
It's terrible and I think it's never going to get any better.	☐	☐	☐	☐
It's awful and I feel that it overwhelms me.	☐	☐	☐	☐
I feel I can't stand it anymore.	☐	☐	☐	☐
I become afraid that the pain will get worse.	☐	☐	☐	☐
I keep thinking of other painful events.	☐	☐	☐	☐
I anxiously want the pain to go away.	☐	☐	☐	☐
I can't seem to keep it out of my mind.	☐	☐	☐	☐
I keep thinking about how much it hurts.	☐	☐	☐	☐
I keep thinking about how badly I want the pain to stop.	☐	☐	☐	☐
There's nothing I can do to reduce the intensity of the pain.	☐	☐	☐	☐
I wonder whether something serious may happen.	☐	☐	☐	☐

Anesthesia History

Have you ever had anesthesia? ☐ Yes ☐ No

Have you ever had complications with anesthesia? ☐ Yes ☐ No

Have you had a spinal anesthetic? ☐ Yes ☐ No

Have you had a general anesthetic? ☐ Yes ☐ No

Have you ever been told you are a difficult intubation? ☐ Yes ☐ No

Do you have dentures, implants, bridges, or loose teeth? ☐ Yes ☐ No

Have you had back surgery with metal implants? ☐ Yes ☐ No

Do you have numbness or tingling in your legs or feet? ☐ Yes ☐ No

Health History Questionnaire

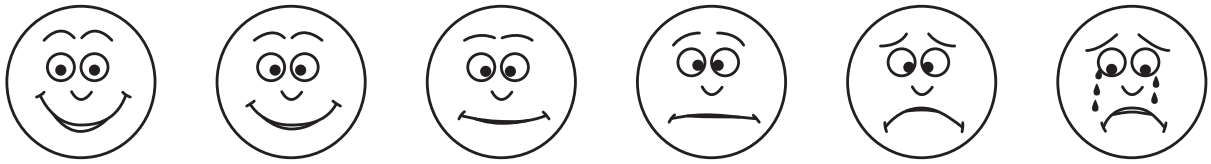
Where is your pain located?

Which side of your body?

How long have you had the pain?

How far can you walk comfortably?

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



0 ☐ 2 ☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐

Other Symptoms: (Check all that apply)

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

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

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

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

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

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

- ☐ Steroids
- ☐ Viscosupplementation (knee gel shots)
- ☐ PRP
- ☐ Stem Cell

Patient Signature _____ Date _____ Time _____

Provider Name_____ Signature _____ Date _____ Time _____