INDIANA JOINT REPLACEMENT INSTITUTE

Patient sticker

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Patient History Questionnaire

Name: _____ **DOB:** _____ **Age:** ____ **Male** **Female**

Marital Status: **Married** **Single** **Widowed** **Divorced**

Work History: **Working** **Retired** **Disabled** **Other:** _____

Occupation: _____

What can we help you with today? **Right** **Left** **Both** **Hip** **Knee**

Tell us what you are experiencing: _____

_____

How long has this been going on? _____

Rate your pain on average: (Scale 0-10; 0=No pain, 10= Worst Pain imaginable): _____

Have you had any treatment of this problem before? **Yes** **No**

If yes, what treatment(s)? _____

_____

Have you had any surgery for this problem before? **Yes** **No**

Type: _____ **Date:** _____

Type: _____ **Date:** _____

List *all* Prescription and Non-Prescription Medications you take ☐ **See Attached List**

Name & Dose (mg)	How often	Name & Dose (mg)	How often

Allergies: **Yes** **No** **If yes, please list medication and reaction to it below:**

Medication	Reaction	Medication	Reaction

Medical History (Check all medical problems you have been or currently are being treated for):

High Blood Pressure		Stroke		Parkinson's Disease	
Heart Disease/Heart Attack		Blood Clots		Multiple Sclerosis	
Irregular Heart Rhythm		Diabetes		Seizures/Epilepsy	
Peripheral Vascular Disease		Cancer		Nerve Injury	
Emphysema/COPD/Asthma		Ulcer		Hepatitis: (circle) A B C	
Sleep Apnea		Kidney Disease		Immunodeficiency Disease (HIV)	
Tuberculosis (TB)		Thyroid Disease		Degenerative Spine Disease/Sciatica	
GERD/Heartburn		Brain Injury		Arthritis/Osteoporosis	
Other:					

Surgical History (List all *other* surgeries you have had): None

Year	Type of Surgery	Year	Type of Surgery

Did you have any complications during or after any of your surgeries? Yes No
If yes, please select and describe below:

	Infection:		Pneumonia:
	Bleeding:		Lung Problems:
	Blood Clot:		Severe Nausea/Vomiting:
	Anesthesia:		Other:

Do you drink alcohol? Yes No If yes: 1-5 6-10 11-15 16-20 >20 drinks/week

Do you currently smoke? Yes No If yes: _____ packs per day for _____years

Did you ever smoke? Yes No If yes, ____ packs per day for ____ years Year Quit:

History of Substance Abuse? Yes No Which Substance: Last use:

Patient Signature: _____ Date: _____

For office use only:

Vital Signs: Temp: _____ BP: _____ HR: _____ RR: _____

Height: _____ Weight: _____ BMI: _____

PA/RN/MA Signature: _____ Date/Time: _____

MD Signature: _____ Date/Time: _____