The Joint Replacement Center at St. Anthony North
Medical History Form

Name:_____ DOB:_____ (Age:_____) Today's Date:_____

History of Present Illness

Weight:_____ Height:_____

What are you being seen for today? Right Knee · Left Knee Right Hip Left Hip
Other: _____

Have you injured this area before? Yes No
If yes,
describe:_____
_____

Was this an injury or an accident: Yes No
If yes, what is the date of injury or accident:_____
Describe the injury or accident in
detail:_____
_____

When did your symptoms start:_____

What are your
symptoms:_____
_____

Level of Pain (10 being the worst) 0 1 2 3 4 5 6 7 8 9 10
Intermittent OR Constant

What treatments have you tried? (Circle all that apply)

Weight Loss Steroid Injections Physical Therapy NSAIDS Tylenol Prescription Pain Meds

Other treatments not
listed:_____
_____

Could you be pregnant? Yes No

Which is your dominant side? Right Left Ambidextrous

Social History

Are you currently employed? Yes No
If yes, current occupation:_____

Marital Status (circle one)

Single Engaged Married Divorced Separated Widowed Partner I live alone

Do you have children? Yes No
If yes, how many:_____

Do you smoke? No Yes - How much per day?_____ Quit - When?_____

Do you use smokeless tobacco? No Yes - How much per day? _____ Quit - When?_____

Do you drink alcohol? No Yes - How much per day? _____ Quit - When?_____

Do you use illegal drugs? No Yes - How much per day?_____ Quit - When?_____

Prescription drug abuse history? No Yes - Drug?_____

Do you drink caffeine? No Yes - What kind and how often?_____

How much exercise do you get?

Sedentary 1 Time/Week 1-3 Times/Week 4+ Times/Week Active but no formal exercise

Do you have any allergies?

_____ _____ _____

_____ _____ _____

Surgeries/ Procedures: **Date of Surgery/Procedure:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Review of Symptoms (Check mark for yes)

___ Activity Change	___ Vertigo
___ Numbness in affected extremity	___ Chest Pain
___ Tingling in affected extremity	___ Shortness of breath
___ Weakness in affected body part	___ Nausea
___ Joint pain in affected body part	___ Incontinence
___ Is there a wound	___ Rash
___ Is there a surgical incision	___ Muscle Weakness
___ Gait Problems	___ Anxiety
___ Joint Swelling	___ Depression
___ Fever/Chills	___ Blood Clots, Bruising, Bleeding
___ Blurry Vision	___ Frequent Illness
___ Headache	

Has any blood relative had any of the following?

(Indicate the family member if yes. M=Mother F=Father S=Sister B=Brother D=Daughter S=Son)

___ Bleeding Disorder If yes, what type?_____	___ Chronic DVT of Leg
___ Clotting Disorder If yes, what type?_____	___ Sudden Cardiac Death
___ Diabetes If yes, which type?_____	___ Muscular Dystrophy
___ Cancer If yes, what type?_____	___ Pulmonary Embolism
___ Arthritis (Osteo or Rheumatoid)	___ Reaction to Anesthesia
___ Cardiovascular Disease	___ Scoliosis
	Other:_____

Past Medical History (check mark for yes)

___ None	___ Peptic Ulcer Disease
___ COPD	___ Peripheral Vascular Disease
___ Coronary Artery Disease	___ Polio
___ Crohn's Disease	___ Pulmonary Embolism
___ Depressive Disorder	___ High Cholesterol
___ Gout	___ Anemia
___ Hepatitis	___ Rheumatoid Arthritis
___ HIV	___ Systemic Lupus
___ Osteoarthritis	___ Thyroid Disorder
___ Osteoporosis	___ Unexplained Weight Gain/Loss
___ High Blood Pressure	
___ Diabetes Mellitus Type I If yes, last A1C:_____	___ Blood Clot in Leg If yes, acute or chronic:_____
___ Diabetes Mellitus Type II If yes, last A1C:_____	___ CVA (Stroke) If yes, when: _____
___ Bleeding Disorder If yes, what type:_____	___ Reaction to Anesthesia If yes, what is the reaction: _____
___ Clotting Disorder If yes, what type:_____	___ Cancer If yes, what type:_____

Other:

List all prescriptions, over the counter medicines and supplements you take

Medication:	Dose/Frequency: