

**CHARLESTON HIP & KNEE REPLACEMENT CENTER**  
**Patient History**

Date: \_\_\_\_\_ Referring MD: \_\_\_\_\_

Name: \_\_\_\_\_ Family MD: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M F Employer: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Last Full-Time Work Date: \_\_\_\_\_

CHIEF COMPLAINT (circle the main reason for today's visit):

Right hip                      Right knee      Other \_\_\_\_\_  
Left hip                      Left knee

HISTORY OF PRESENT ILLNESS (circle choices or fill in blanks)

The main problem is: pain, stiffness, swelling, instability, difficulty walking, other \_\_\_\_\_

Is this the result of an injury?    Yes    No                      Where \_\_\_\_\_

When did the injury occur or problem start? \_\_\_\_\_

Pain Severity: none, mild, moderate, severe

When does it bother you most? at rest, walking, stairs, getting up from chair,  
after activity, day, night, lying on side, kneeling, dressing, other \_\_\_\_\_

How far can you walk? Unlimited, \_\_\_\_\_ blocks, indoors only, unable to walk

Modifying factors: Improves with rest, ice, heat, nothing, other \_\_\_\_\_

Have you seen an orthopaedist for this problem?    Yes    No  
Have you tried any bracing for this?                      Yes    No  
Have you tried physical therapy/exercises for this?    Yes    No  
Have you had any injections for this?                      Yes    No  
Have you taken any medication for this?                      Yes    No  
Any prior surgery in the involved area?                      Yes    No  
Do you use? Cane    walker    crutches    wheelchair

Associated Signs & Symptoms: swelling, stiffness, radiating pain, other \_\_\_\_\_

FAMILY/SOCIAL HISTORY:

Occupation: \_\_\_\_\_

Do you exercise?    No    Yes    If yes, what type of exercise? \_\_\_\_\_  
Do you live alone?    No    Yes  
Do you smoke?    No    Yes    If yes, how much and how long? \_\_\_\_\_  
Do you drink alcohol?    No    Yes    If yes, how much and how often? \_\_\_\_\_  
Do you use "drugs"?    No    Yes

Family Medical History (list family illnesses):

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REVIEW OF SYSTEMS/PAST MEDICAL HISTORY (Please check below all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Fever                             | <input type="checkbox"/> Lupus                        |
| <input type="checkbox"/> Weight loss                       | <input type="checkbox"/> Paget's Disease of Bone      |
| <input type="checkbox"/> Chronic fatigue                   | <input type="checkbox"/> Anemia                       |
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> History of blood clot/DVT/PE |
| <input type="checkbox"/> Burning eyes                      | <input type="checkbox"/> Bleeding tendency            |
| <input type="checkbox"/> Glaucoma                          | <input type="checkbox"/> Frequent Falls               |
| <input type="checkbox"/> Hearing loss                      | <input type="checkbox"/> Dizziness/Balance problems   |
| <input type="checkbox"/> Active dental problems            | <input type="checkbox"/> Parkinson's Disease          |
| <input type="checkbox"/> Shortness of breath               | <input type="checkbox"/> Alzheimer's Disease          |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Weakness                     |
| <input type="checkbox"/> Sleep apnea                       | <input type="checkbox"/> Numbness                     |
| <input type="checkbox"/> Heart problems or stent           | <input type="checkbox"/> Stroke or mini stroke        |
| <input type="checkbox"/> High blood pressure               | <input type="checkbox"/> Cerebral Palsy               |
| <input type="checkbox"/> High cholesterol                  | <input type="checkbox"/> Polio                        |
| <input type="checkbox"/> Pacemaker/Defibrillator           | <input type="checkbox"/> Depression                   |
| <input type="checkbox"/> Circulatory problems              | <input type="checkbox"/> Severe Anxiety               |
| <input type="checkbox"/> Ulcers                            | <input type="checkbox"/> Drug abuse                   |
| <input type="checkbox"/> Hepatitis/liver problem           | <input type="checkbox"/> Alcoholism                   |
| <input type="checkbox"/> Intestinal problems               | <input type="checkbox"/> Schizophrenia                |
| <input type="checkbox"/> Urinary problems                  | <input type="checkbox"/> Rash, dermatitis, eczema     |
| <input type="checkbox"/> Possibly pregnant now             | <input type="checkbox"/> Psoriasis                    |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Environmental allergies      |
| <input type="checkbox"/> Thyroid problems                  | <input type="checkbox"/> Metal allergy                |
| <input type="checkbox"/> History of broken bones           | <input type="checkbox"/> Anesthesia problems          |
| <input type="checkbox"/> Fibromyalgia                      | <input type="checkbox"/> Poor or slow healing         |
| <input type="checkbox"/> Gout                              | <input type="checkbox"/> Infection after surgery      |
| <input type="checkbox"/> Osteoporosis                      | <input type="checkbox"/> Current or Recent infection  |
| <input type="checkbox"/> Rheumatoid arthritis              | <input type="checkbox"/> HIV or AIDS                  |
| <input type="checkbox"/> Ankylosing Spondylitis            | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Chronic or intermittent back pain | <input type="checkbox"/> Tuberculosis                 |

Other health issues not listed above:

Prior Surgeries (type of surgery and year):

DRUG ALLERGIES (list all):

MEDICATIONS CURRENTLY TAKING (list all):

Patient/Guardian Signature \_\_\_\_\_

Please Fax To: (843) 724-2633