The Idaho Clinic
HIP AND KNEE REPLACEMENT

ANNUAL HEALTH HISTORY

NAME: _____DOB: _____DATE: _____

Which joint(s) are you being seen for today?

☐ Knee ☐ Hip

☐ Right ☐ Left ☐ Both ☐ Right ☐ Left ☐ Both

How severe is your pain on a scale of 1-10? _____

Type of pain (check all that apply): ☐ Sharp ☐ Dull ☐ Constant ☐ Comes and goes

How long have you had pain? : _____

List your MEDICATIONS, including over-the-counter (OTC) medications/supplements.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have any allergies?

☐ NONE
☐ Medication Allergies _____
☐ Metal or Jewelry
☐ Latex ☐ Sutures ☐ Tape
☐ Other: _____

Reactions (if applicable):

☐ Redness/itchy/rash ☐ Nausea/Vomiting
☐ Anaphylaxis ☐ Childhood
☐ Altered mental status/hallucinations
☐ Other reactions:_____

Medical History: Mark all that apply

☐ Diabetes, A1C _____
☐ Liver problems
☐ Thyroid Problems
☐ Stomach ulcers
☐ Chronic kidney disease
☐ Hiatal hernia
☐ Urinary tract infections
☐ Gallbladder problems
☐ Gout
☐ Psoriasis
☐ Osteoporosis
☐ Rheumatoid arthritis

☐ Heart disease/Heart Attack
☐ High blood pressure
☐ Elevated cholesterol
☐ Atrial fibrillation
☐ Bleeding tendencies/disorder
☐ Asthma
☐ Sleep apnea
☐ Blood clots
☐ Stroke
☐ Fibromyalgia
☐ MRSA/MSSA infection
☐ Cancer (type):_____
☐ Other:_____

SURGICAL HISTORY: Please list all prior surgeries and approximate dates performed.

Surgery	Year/Surgeon Name	Complications

Continued on other side.

SOCIAL HISTORY:

Current Living Situation: ☐ Alone ☐ with Spouse ☐ with Roommate ☐ Other:_____

Occupation/Former Occupation: _____ Retired? ☐ Yes ☐ No

SOCIAL HISTORY:

Do you drink alcohol? ☐Yes ☐No If yes, how much/week? _____

Do you use nicotine (smoke, chew or vap**e)**? ☐Yes ☐No If yes, how many per day? _____

Do you use recreational drugs? ☐Yes ☐No If yes, what type and frequency?_____

FAMILY HISTORY:

Check all medical problems anyone in your immediate family (Mother, Father, Brother, Sister) has had:

☐ Arthritis ☐ Heart problems ☐ Diabetes ☐ Anesthesia problems ☐ Blood clots ☐ Bleeding problems

List other medical providers you see on a regular basis (i.e. Primary Care, Cardiologist, Mental Health Provider, Kidney Doctor, etc):

_____

Review of systems: Mark all that apply

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Eating disorder

Neurological
- ☐ Migraine
- ☐ Head injury
- ☐ Memory loss
- ☐ Numbness/tingling

Cardiovascular
- ☐ Irregular heartbeat
- ☐ Varicose veins
- ☐ Chest pain/angina
- ☐ Sleep Apnea
- ☐ Swelling feet/ankles

Gastrointestinal
- ☐ Change in bowel movements
- ☐ Nausea/vomiting
- ☐ Heartburn/acid reflux

Genitourinary
- ☐ Burning/painful urination
- ☐ Bladder problems
- ☐ Prostate problems
- ☐ Urinary tract infections

Musculosketal
- ☐ Difficulty with balance
- ☐ Limping

Pain, stiffness or swelling in:
- ☐ Arms
- ☐ Hands
- ☐ Shoulders
- ☐ Neck
- ☐ Back
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet

Patient Signature: _____ Date: _____