Dr. Klimisch's

TOTAL JOINT WORKSHEET

Patient full name:____ **Date:**_______________

Please **circle** the affected joint: [Right Hip] [Left Hip] [Right Knee] [Left Knee]

Which bothers you **the most**? [Right Hip] [Left Hip] [Right Knee] [Left Knee]
(Circle ONLY ONE)

Do you use… [Cane] [Walker] [Crutches] [Wheelchair] [None]
(Circle all that apply)

How long has the affected joint been bothering you? _____________________________________

What makes the pain **better**? ____
____

What makes the pain **worse**? ____
____

How far can you walk **without pain**? **(Circle only ONE)**
[None] [Housebound] [<1Block] [<5 Blocks] [5-10 Blocks] [Unlimited]

How many steps can you climb? __________________ Do you use the rail? ☐**Yes** ☐**No**

Do you experience stiffness or limited ROM in the affected joint? ☐**Yes** ☐**No**

Have you had physical therapy for the affected joint? ☐**Yes** ☐**No**
If yes, when? ___________________ Did it help? ____

Have you tried ***anti-inflammatories*** such as Advil, Ibuprofen, or Tylenol? ☐**Yes** ☐**No**
If yes, what have you tried? ____

Have you tried pain medications such as hydrocodone, ultram? ☐**Yes** ☐**No**
If yes, what have you tried? ____

Have you had therapeutic injections such as: ☐ **Steroid** ☐**Viscosupplement**
If yes, Please put the ***type and the date***: ____
Did it help? ____

Have you tried weight loss to decrease the pain? ☐**Yes** ☐**No**

Please describe how pain has limited your activities ____
____

PLEASE ANSWER ALL QUESTIONS FULLY.

First, Last MI.____

Date of Birth: _____/_______/_________ Age:________________ Sex: ☐Female ☐Male

Height ________________________ Weight:____________________________ BMI: ____________

****We will measure height and weight at your appointment as well****

Please answer all questions below **fully.**

Please list **ALL allergies** and adverse reactions below:___________________

____

____

____

____

____

____

____

____

____

____

****Please check below if you** have no known allergies:

☐ **NO ALLERGIES**

Medical History	YES	NO	Details:
Heart Disease/Problems			
High Blood Pressure			
Diabetes			
Asthma			
Emphysema			
Cancer			Type:
Stroke			When:
Gout/Pseudogout			
Kidney Diseases			
Seizure/ Neurologic diseases			Type:
Stomach ulcers			
Skin problems			
Bleeding problems			
DVT			
Non-healing wounds			
Psychiatric issues			
Ear/Nose/Mouth/ Throat problems			
Gum disease/ Tooth abscess			
Prostate gland disorder			
Hx of MRSA			
Sleep apnea			
Other			Specify:

Please list **ALL** medications ***AND*** the *reason you take them* below (you may write on the back of this page if necessary):

____

____

____

____

____

____

____

Surgical History

Please list any previous surgeries/ procedures below:

____

____

____

____

____

Do you have a history of complications from surgery or anesthesia? ☐ **Yes** ☐ **No**

If yes, please explain: ____

Do you have an advanced directive or power of attorney? ☐**Yes** ☐**No**

Please check ***yes or no for each below:***

Family History	**YES**	**NO**	**Family Member**
Heart Disease/Problems			
High Blood Pressure			
Diabetes			
Asthma			
Emphysema			
Cancer			
Stroke			
Gout/Pseudogout			
Kidney Diseases			
Seizure/ Neurologic diseases			
Stomach ulcers			
Skin problems			
Bleeding problems			
DVT			
Non-healing wounds			
Psychiatric issues			
Ear/Nose/Mouth/ Throat problems			
Gum disease/ Tooth abscess			
Prostate gland disorder			
Hx of MRSA			
Sleep apnea			
Other			

Social History:

Please check the correct box for each question below.

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐Widowed

Living situation:

☐ Alone ☐ With others

Is your residence single story or multi-level ?

☐ Single Story ☐ Multi-level

Do you have children?

☐ Yes ☐ No **If yes, how many?** ____________________

If yes, how many are still at home? ________________

Do you use tobacco?

☐Yes ☐No ☐Former

If yes, amount and type:_________________________

Do you drink alcohol?

☐Yes ☐No ☐Occasionally

If yes, amount and type:_________________________

Do you do any recreational drugs?

☐Yes ☐No

If yes, amount and type: _________________________

How often do you exercise? ☐Never ☐Rarely ☐Weekly ☐Daily **If yes, type:**_________________________

What is your **current occupation**? ________________

____

1.Who is your **primary care provider**/ physician? ____________________

2.Do you have any other **specialists** that you see?____________________

____

____

Please check under the **yes or no** column for **EACH symptom**:

Constitutional Symptoms	Yes	No	Eyes	Yes	No	Skin	Yes	No
Fever			Blurred Vision			Rash		
Chills			Double vision			Boils		
Body ache			Pain			Itching		

Genitourinary	Yes	No	Neurological	Yes	No	Hematologic	Yes	No
Urine retention			Tremors			Hepatitis		
Painful urination			Dizzy spells			Anemia		
Frequent urination			Numbness			HIV		
Kidney stones			Paralysis			Do you take coumadin?		

Endocrine	Yes	No	Cardiovascular	Yes	No	Respiratory	Yes	No
Excessive thirst			Chest Pain			Sleep Apnea		
Too hot/cold			Swelling of hands/ feet			Wheezing		
Tired/sluggish			Abnormal heartbeat			Cough		
Weight gain			Varicose veins			Short of breath		
Weight loss			High blood pressure			Tuberculosis		

Psychologic	Yes	No
Are you satisfied with your life?		
Do you feel depressed?		
Anxiety disorder		

ENT	Yes	No
Hearing loss		
Ear infection		
Frequent nose bleeds		
Bleeding gums		
Sore throat		

Gastro-intestinal	Yes	No
Abdominal Pain		
Loss of appetite		
Change in Bowel movements		
Nausea/ vomiting		
Frequent diarrhea		
Blood in stool		
Trouble swallowing		
Heartburn		

We look forward to seeing you soon!