TEXAS CENTER *for*
JOINT REPLACEMENT

MEDICAL HISTORY

Name: _____ Date: _____ DOB: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Primary Care Physician: _____ Primary Care Physician Phone: _____

CHIEF COMPLAINT

Which joint is bothering you: Hip Knee Shoulder Elbow Ankle

Side: ◯ Right ◯ Left ◯ Both

SOCIAL HISTORY

Alcohol use: ◯ Never ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly

Frequency (ex: 2x per week): _____

Tobacco use: ◯ Current Smoker ◯ Former Smoker ◯ Never Smoked

Packs per Day: _____ How many years? _____ Quit Date: _____

FAMILY HISTORY

Please check all that apply: (M)other (F)ather (B)rother (S)ister (G)randparent

Joint Replacement: ◯ M ◯ F ◯ B ◯ S ◯ G

Osteoarthritis: ◯ M ◯ F ◯ B ◯ S ◯ G

Osteoporosis: ◯ M ◯ F ◯ B ◯ S ◯ G

Rheumatoid Arthritis: ◯ M ◯ F ◯ B ◯ S ◯ G

ALLERGIES

If you have a typed list of your allergies, please bring it to the check-in counter once this form is completed and proceed to the next page.

Allergy	Reaction	Allergy	Reaction

Metal or Jewelery Allergy: ◯ Yes ◯ No If yes, which type: _____

Tape Allergy: ◯ Yes ◯ No

Latex Allergy: ◯ Yes ◯ No

Name: Date: DOB:

Medication

If you have a typed list of your medications, please bring it to the check-in counter once this form is completed and proceed to the surgical history at the bottom of this page

Medication	Dose	Frequency	Medication	Dose	Frequency

Surgical History		Year	**Surgical History**		Year
○ Appendix Removal			○ Hip Scope	○ R ○ L ○ B	
○ Ankle Surgery	○ R ○ L ○ B		○ Hysterectomy		
○ Back Surgery			○ Intestinal Surgery		
○ Bladder Surgery			○ Kidney Stone Surgery		
○ Brain Surgery			○ Knee Replacement	○ R ○ L ○ B	
○ Carpal Tunnel Repair	○ R ○ L ○ B		○ Knee Scope	○ R ○ L ○ B	
○ Cataract Surgery	○ R ○ L ○ B		○ Lasik		
○ Colon Surgery			○ Mastectomy		
○ C-Section			○ Neck Surgery		
○ DVT Surgery/Filter			○ Pacemaker		
○ Elbow Surgery	○ R ○ L ○ B		○ Prostate Surgery		
○ Gall Bladder Surgery			○ Shoulder Replacement	○ R ○ L ○ B	
○ Gastric Bypass/Sleeve			○ Shoulder Scope	○ R ○ L ○ B	
○ Heart Bypass			○ Thyroidectomy		
○ Heart Stents			○ Tonsillectomy		
○ Heart Valve Replacement			○ Vein Surgery		
○ Hernia Repair	○ R ○ L ○ B		○ Other:		
○ Hip Fracture/IM Nail	○ R ○ L ○ B		○ Other:		
○ Hip Replacement	○ R ○ L ○ B		○ Other:		

Name: _____ Date: _____ DOB: _____

Have you had any of the following:

Cardiovascular
- ○ Aortic Stenosis
- ○ Atrial Fibrillation
- ○ Carotid Artery Disease
- ○ Chest Pain
- ○ Congestive Heart Failure
- ○ Coronary Artery Disease
- ○ Heart Attack (MI)
- ○ Heart Murmur
- ○ Heart Valve Issues
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ High Triglycerides
- ○ Irregular Heartbeat

Metabolic
- ○ Diabetes Mellitus, Type I
- ○ Diabetes Mellitus, Type II
- ○ Low Blood Sugar
- ○ Thyroid Disease

Gastrointestinal
- ○ Colitis
- ○ Crohn's Disease
- ○ Diverticulosis/Diverticulitis
- ○ Gall Bladder Problems
- ○ Heartburn/Reflux
- ○ Liver Disease
- ○ Pancreatitis
- ○ Ulcers

Blood
- ○ Anemia
- ○ Blood Clots/DVT
- ○ Hemophilia/Free Bleeder
- ○ Prior Blood Transfusions
- ○ Pulmonary Embolism
- ○ Sickle Cell Anemia

Musculoskeletal
- ○ Ankylosing Spondylitis
- ○ Back/Neck Pain
- ○ Fibromyalgia
- ○ Gout
- ○ Lupus
- ○ Osteoporosis
- ○ Paget's Disease
- ○ Perthes Disease
- ○ Rheumatoid Arthritis
- ○ Sciatica
- ○ Scoliosis

Neurological
- ○ Alzheimer's Disease/Dementia
- ○ Carpal Tunnel
- ○ Chronic Headaches
- ○ Foot Drop
- ○ Migraines
- ○ Neuropathy
- ○ Numbness
- ○ Parkinson's Disease
- ○ Seizures/Epilepsy
- ○ Stroke
- ○ Tremor

Eyes/Ears/Nose/Skin
- ○ Cataracts
- ○ Eczema
- ○ Glaucoma
- ○ Hearing Loss
- ○ Nose Bleeds
- ○ Non-Healing Wounds
- ○ Psoriasis
- ○ Skin Ulcers
- ○ Skin Infections

Urinary
- ○ Bladder Prolapse
- ○ Kidney Disease
- ○ Kidney Stones
- ○ Prostate Trouble
- ○ Urinary Incontinence

Respiratory
- ○ Asthma
- ○ Bronchitis
- ○ COPD/Emphysema
- ○ Pneumonia
- ○ Sleep Apnea

Psychological
- ○ Alcohol Addiction
- ○ Anxiety
- ○ Bipolar
- ○ Depression
- ○ Drug Addiction

Infections
- ○ Hepatitis
- ○ Herpes
- ○ HIV/AIDS
- ○ Malaria
- ○ Rheumatic Fever
- ○ Tuberculosis
- ○ Wound Infection

Cancer
- ○ _____
- ○ _____
- ○ _____
- ○ _____

Bone Fractures
- ○ _____
- ○ _____
- ○ _____
- ○ _____

Other Illnesses
- ○ _____
- ○ _____
- ○ _____
- ○ _____

Patient Signature: _____ Date: _____