University of Connecticut
Health Center
UCONN Medical Group
Orthopaedic Surgery

(Patient Identification)

Center for Joint Preservation and Replacement New Patient Questionnaire

Name: _____ **DOB:** _____ **Age:** _____ **M** ☐ **F** ☐

Chief Complaint: Right ☐ **Left** ☐ **Both** ☐ **Hip** ☐ **Knee** ☐

History of Problem: _____

Duration (Length of Time); _____

Intensity of Pain (Scale 0-10; 0=No pain, 10= Worst Pain imaginable): _____

Past Treatments for this problem: _____

Previous Surgeries on this area: **Yes** ☐ **No** ☐

Type: _____ **Date:** _____

Type: _____ **Date:** _____

List all Medications you take regularly (include non-prescription meds): ☐ **See Attached List**

Name & Dose (mg)	How often	Name & Dose (mg)	How often

Allergies: **Yes** ☐ **No** ☐ **If yes, please list medication and reaction to it below:**

Medication	Reaction	Medication	Reaction

Medical History (Check all medical problems you have been or currently are being treated for):

	High Blood Pressure		Stroke		Parkinson's Disease
	Heart Disease/Heart Attack		Blood Clots		Multiple Sclerosis
	Irregular Heart Rhythm		Diabetes		Seizures/Epilepsy
	Peripheral Vascular Disease		Cancer		Nerve Injury
	Emphysema/COPD/Asthma		Ulcer		Hepatitis A ☐ B ☐ C ☐:
	Sleep Apnea		Kidney Disease		Immunodeficiency Disease (HIV)
	Tuberculosis (TB)		Thyroid Disease		Degenerative Spine Disease/Sciatica
	GERD/Heartburn		Brain Injury		Arthritis/Osteoporosis

Surgical History (List all *other* surgeries you have had):

Year	Type of Surgery	Year	Type of Surgery

Complications (Check and explain any complications you have had after any of your surgeries):

	Infection:		Pneumonia:
	Bleeding:		Lung Problems:
	Blood Clot:		Severe Nausea/Vomiting:
	Anesthesia:		Other:

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Review of Systems (Check any recent/current problems, circle symptoms or write in Other):

	System	Symptoms/Problems	Other
	General	Fever, Unexplained weight loss/gain, Weakness	
	Eyes/Vision	Glasses, Blurred, Double, Dry Eyes	
	Ears, Nose, Throat	Vertigo, Sinusitis, Hoarseness, Loss of Hearing	
	Heart	Chest pain, Murmurs, Palpitations Irreg. Rhythm	
	Lungs	Short of Breath, Asthma, Cough, Wheezing	
	Circulation	Blood clot, Swelling, Claudication, Varicosities	
	Digestive Tract	Diarrhea, Constipation, Ulcers, GERD, Pain	
	Kidney/Urinary	Stones, Burning, Itching, Bleeding	
	Skin/Breast	Rash, Lump, Itching, Hair or Nail changes	
	Endocrine	Excess Thirst, Decreased Energy, Diabetes	
	Neurologic	Balance, Numbness/Tingling, Seizure, Tremor	
	Psychiatric	Depression, Anxiety, Sleep Disorder	
	Blood/Lymph	Bleeding Problems, Easy bruising, Transfusion	
	Musculoskeletal	Fracture, Arthritis, Motion loss, Cramps/Spasm	

Social History:

Occupation: Full Time ☐ Part Time ☐ Retired ☐
Do you drink alcohol? Yes ☐ No ☐ How much?(circle) 1-5 6-10 11-15 16-20 >20 drinks/week
Do you currently smoke? Yes ☐ No ☐ If yes, # of packs per day (ppd): for # of years:
Did you ever smoke? Yes ☐ No ☐ If yes, # of ppd: for # of years: Year Quit:
History of Substance Abuse? Yes ☐ No ☐ What Substance:

Family History (Mark any conditions that your parents or siblings have/had by indicating the family member (M=Mother, F=Father, B=Brother, S=Sister) after the condition):

High Blood Pressure:	**Asthma:**	**Cancer:**
Heart Attack:	**Lung Disease:**	**Stroke:**
Coronary Artery Disease:	**Tuberculosis:**	**Diabetes:**
Heart Valve Disease:	**Thyroid Disease:**	**Kidney Disease:**
Irregular Heart Rhythm:	**Blood Clots:**	**Arthritis:**
Peripheral Vascular Disease:	**Seizures:**	**Osteoporosis:**
Hepatitis A ☐ B ☐ C ☐:	**Immunodeficiency:**	**Other: :**

Patient Signature: _____ **Date/Time**_____

MD Signature: _____ **Date/Time:** _____

Vital Signs: **Temp:** _____ **BP:** _____ **HR:** _____ **RR:** _____

Height: _____ **Weight:** _____ **BMI:** _____

Medical Assistant Signature: _____ **Date/Time:** _____