ZEHRCENTER
ORTHOPAEDICS
...because living with pain *isn't* really living!®

Name:____**Age**:_____**DOB**:______________

Reason For Visit: **Hip L R Both** **Knee L R Both**

Any Previous Surgeries or Injections on the Joint Being Evaluated:______________________

____

If Yes to Previous Surgeries of the area being evaluated Please List:

Type of Surgery, Date of Surgery and Physician that Performed Surgery:

____

Have you had RECENT X-RAYS (within the last 3 months): Yes or No

If yes: Where were they taken?____

Do You Have the Images on a Disk?____

Referring Physician:____

Primary Care Physician:____

Medication Allergies:____

Medications:____

____

Past Surgical History:

____

____

____

Past Medical History:

Cardiac:

Hypertension, Cholesterol, Heart Attack, Heart Failure, Pacemaker, Irregular Rhythm,

Other:____

Gastro-Intestinal:

Hernia, Ulcers, Gastritis, Pancreatitis, GERD, IBS, Diverticulitis, Colitis, Hepatitis,

Other:____

Immune/Endocrine:

Diabetes, Hypothyroidism, Immunodeficiency, Psoriasis,Eczema,

Other:____

Ears, Nose, Throat:

____

Renal/Urology:

Kidney Disease, Recurrent UTI's/Bladder Infections, Incontinence, Prostatitis, Kidney Stones,

Other:____

Musculoskeletal:

Joint Replacement, Osteoarthritis, Rheumatoid Arthritis, Fibromyalgia,

Other:____

Neurological:

Headaches, Seizures, Stroke, TIA, Head Injury,

Other:____

Pulmonary:

Asthma, COPD, Tuberculosis, Sleep Apnea, Pulmonary Embolism,

Other:____

Family History:

Father: Living or Deceased Age:______ Cause of Death if Deceased:_______________

Mother: Living or Deceased Age:______ Cause of Death if Deceased:_______________

Social History:

Married Single Widowed Divorced

Children: Yes or No **How Many?**____

Employment: Working or Retired Occupation:________________________

Full-Time or Part-Time Florida Resident? ____________________________________

If Part-time Where?____

Current or Past Smoker:____________Packs per day:___________________________

Quit Date:____________

Do you consume Alcohol?___________Frequency: Daily Weekly Socially

Caffeine use: Coffee Soda Tea Servings Per Day:______________________

Do you exercise or play sports?____

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