

ALBERT J. FOLGUERAS, M.D.

Hip/Knee Replacement, Arthroscopy, Minimally Invasive Surgery,
Sports Medicine, Fracture Care

Name: _____ Date of Birth: _____ Date: _____

Who sent you to see us? Name: _____

Address: _____ City, State, Zip _____

Phone: _____

Why are you seeing the doctor today? _____

Where is your pain? Right Hip Right Knee Back
 Left Hip Left Knee

How long have you had this problem? _____

If you are having **HIP PAIN**, where is it located?

Groin Thigh Down below knee
 Side of Hip Down to knee Down to foot

If you are having **KNEE PAIN**, where is it located?

Inside of the knee (close to the other knee) Front of the knee (under kneecap)
 Outside of knee (away from the other knee) Back of knee

Is your pain: Getting Worse Getting Better Staying the same

Is your pain: Intermittent Constant

How would you describe your pain?

Sharp Throbbing Burning
 Dull Tight Tingling

Do you have pain when you:

Walk Sit
 Stand At night

Is your pain worse when you:

Walk Sit
 Stand At night

Rate your pain on a scale from 1-10 (1 = minimal pain, 10 = severe pain): _____

Do you have any of the following:

Stiffness Numbness
 Swelling Weakness

Do you have a limp?

None Moderate
 Slight Severe

How far can you walk BEFORE you start having pain?

Unlimited 2-3 blocks 4-6 blocks
 Bed to chair only Indoors only Unable to walk

How many stairs do you walk up **to get into** your home? _____

How many stairs do you walk up **inside** your home? _____

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Name: _____

Do you need assistance with walking?

- None
- Cane, long walks only
- Cane all of the time
- Walker
- Wheelchair

Do you have difficulty going up or down stairs?

- None
- Use of banister always
- Take one step at a time
- Use of crutches or cannot do stairs

Do you have difficulty putting on your shoes and socks?

- None
- With difficulty
- Unable

Can you sit in a chair comfortably for:

- Any chair for more than 1 hour
- High chair for 1/2 hour
- Unable to sit for 1/2 hour

Can you get up from a chair:

- Normally
- Use my arms
- Difficulty even when using my arms
- Need help, unable to do alone

Have you tried any of the following medications?

- Tylenol
- Aspirin
- Vioxx
- Celebrex
- Motrin
- Aleve
- Other _____

Have you tried injections?

- Yes
- No

If yes, what kind of injections?

- Steroids
- Synvisc
- Do not know

How many injections? _____

Have your tried physical therapy/exercises?

- Yes
- No

PAST MEDICAL HISTORY

Please list all of your medical problems (such as high blood pressure, heart disease, diabetes):

Please list all of your past surgeries/hospitalizations/severe injuries with dates (Month/Year):

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Name: _____

Do you have any allergies to any medications? _____

What medications do you presently take (include name and dose):

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

SOCIAL HISTORY

What kind of work do you do?

- | | |
|--|--|
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Manual labor |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Desk job |
| <input type="checkbox"/> On disability | <input type="checkbox"/> Occupation: _____ |

Marital Status: Single Married Divorced Widowed

Do you have children? Yes No How many children? _____

Who lives at home with you? _____

- | | | | |
|-------------------------------|------------------------------|-----------------------------|----------------------------------|
| Do you drink alcohol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, # drinks per week: _____ |
| Do you smoke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, # packs per day: _____ |
| | | | For how many years? _____ |
| Do you use illicit drugs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Describe: _____ |
| Do you exercise regularly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How many times per week? _____ |
| Do you follow a special diet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | What kind? _____ |

FAMILY HISTORY

Member	Alive/Deceased	Age	Health Status/Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			

OTHER INFORMATION

Height: _____ Weight: _____

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Name: _____

Do you currently or have you ever had problems with any of the following that you did NOT list elsewhere?

Constitutional

- Recent weight loss Yes No
- Recent fevers Yes No

Eyes

- Wear glasses Yes No
- Cataracts Yes No
- Glaucoma Yes No

Ears, Nose, Throat, Mouth

- Sinus problem Yes No
- Active dental problem Yes No

Cardiovascular

- Heart attack Yes No
- Heart murmur Yes No
- Irregular heart beat Yes No
- High blood pressure Yes No
- High cholesterol Yes No
- Valve problem Yes No

Respiratory

- Asthma Yes No
- Bronchitis Yes No
- Emphysema Yes No
- Pneumonia Yes No
- Tuberculosis Yes No

Gastrointestinal

- Colitis Yes No
- Diverticulitis Yes No
- Ulcer Yes No
- Hernia Yes No
- Hepatitis or liver problem Yes No

Genitourinary

- Prostate problem Yes No
- Kidney problem Yes No
- Frequent bladder infections Yes No

Musculoskeletal

- Rheumatoid Arthritis Yes No
- Ankylosing Spondylitis Yes No
- Lupus Yes No
- Osteoporosis Yes No
- Paget's Disease Yes No

Skin

- Psoriasis Yes No
- Eczema Yes No
- Dermatitis Yes No

Neurologic

- Seizures/Epilepsy Yes No
- Polio Yes No
- Parkinson's Disease Yes No
- Alzheimer's Disease Yes No
- Balance problems Yes No

Psychiatric

- Depression Yes No
- Schizophrenia Yes No

Endocrine

- Diabetes Yes No
- Thyroid Yes No

Hematologic/Blood

- Blood Clots Yes No
- Anemia Yes No

Cancer

- What kind? Yes No _____

OTHER

