Specialists list for New Patients

Patient Name: _____

Please list the name(s), address and phone number of all the **Specialists** you are currently receiving care from.

Specialty_____
Name _____
Address: _____
Contact #:_____

Specialty_____
Name _____
Address:_____
Contact #:_____

Specialty_____
Name _____
Address: _____
Contact #:_____

Specialty_____
Name _____
Address: _____
Contact #:_____

DOB:
DOS:
ATT:
FIN:
MRN:

DOB:
DOS:
ATT:
FIN:
MRN:

FOLLOW UP SHEET – DR. LONGJOHN

ALL RADIOLOGICAL STUDIES REQUIRE AUTHORIZATION

(EXCEPT – Medicare)

Stat:_____ Urgent:_____ Routine:_____

DIAGNOSIS: RT/LT/BIL: _____

TYPE OF INS: W/C AUTH._____ HMO AUTH._____ PPO PRE-CERT._____

BOOK SURGERY WITH NORMA:_____

F/UP VISIT: _____ W/X-RAYS: _____

LAB:_____

P.T. _____ SYNVISIC ONE: _____ PAIN MANAGEMENT:_____

CT SCAN 3D RECON. _____

MRI W/CONTRAST:_____ NO CONTRAST: _____

NOTES: _____

_____

_____

_____

Name: _____ Date of Birth: _____ ☐ 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 treatment for this problem: _____

Previous Surgeries on this area: ☐ No ☐ Yes

Type: _____ Date: _____

Type: _____ Date: _____

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

N	Y		N	Y		N	Y	
		High Blood Pressure			Stroke			Parkinson's Disease
		Heart Disease/Heart Attack			Blood Clots			Multiple Sclerosis
		Irregular Heart Rhythm			Diabetes			Seizure/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

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

Name & Dose	How Often	Name & Dose	How Often

ORTHOPAEDIC SURGERY
CENTER FOR JOINT PRESERVATION & REPLACEMENT
NEW PATIENT QUESTIONNAIRE

PATIENT ID

DOB:
DOS:
ATT:
FIN:
MRN:

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

Medication	Reaction	Medication	Reaction

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 Reaction:		Other:

Social History:

Occupation: _____ ☐ Full Time ☐ Part ☐ Retired

Do you drink alcohol? ☐ No ☐ Yes If yes, how much? ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 20 or more drinks/week

Do you currently smoke? ☐ No ☐ Yes If yes, number of packs per day: _____ For _____ years

Did you ever smoke? ☐ No ☐ Yes If yes, number of packs per day: _____ For _____ years Year quit: _____

History of Substance Abuse? ☐ No ☐ Yes If yes, what substance: _____

Review of Symptoms (Check any recent/current problems, check symptoms or write in other):

N	Y	System	Symptoms/Problems	Other
		General	☐ Fever, ☐ Unexplained Weight Loss/Gain, ☐ Weakness	
		Eyes/Vision	☐ Glasses, ☐ Blurred, ☐ Double, ☐ Dry Eyes	
		Ears, Nose, Throat, Mouth	☐ Vertigo, ☐ Sinusitis, ☐ Hoarseness, ☐ Loss of Hearing	
		Heart	☐ Chest Pain, ☐ Murmurs, ☐ Palpitations, ☐ Irregular Rhythm	
		Lung	☐ Short of Breath, ☐ Asthma, ☐ Cough, ☐ Wheezing	
		Circulation	☐ Blood Clots, ☐ Swelling, ☐ Claudication, ☐ Varicosities	
		Digestive Tract	☐ Diarrhea, ☐ Constipation, ☐ Ulcers, ☐ GERD, ☐ Pain	
		Kidney/Urinary	☐ Stones, ☐ Burning, ☐ Itching, ☐ Bleeding	
		Skin/Breast	☐ Rash, Lump, ☐ Itching, ☐ Hair or Nails Change	
		Endocrine	☐ Excess Thirst, ☐ Decreased Energy, ☐ Diabetes	
		Neurologic	☐ Balance, ☐ Numbness/Tingling, ☐ Seizure, ☐ Tremor	
		Psychiatric	☐ Depressions, ☐ Anxiety, ☐ Sleep Disorder	
		Blood/Lymph	☐ Bleeding Problems, ☐ Easy Bruising, ☐ Transfusion	
		Musculoskeletal	☐ Fracture, ☐ Arthritis, ☐ Motion Loss, ☐ Cramps/Spasms	

PATIENT ID

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

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:

I certify that the foregoing statements are true to the best of my knowledge.

Patient Signature: _____ Date: _____ Time: _____

Physician (Print): _____ (Signature): _____ Date: _____ Time: _____

Vital Signs:

Temp: _____ BP: _____ HR: _____ RR:_____ Pain: _____ Height: _____ Weight: _____ BMI: _____

Narcotics Use Question for Patients Completing Questionnaire:
Has it been more than 90 days since the patient's last use of chronic narcotics? ☐ No ☐ Yes

Medical Assistant (Print): _____ (Signature): _____ Date: _____ Time: _____

PATIENT ID

DOB:
DOS:
ATT:
FIN:
MRN:

Donald B. Longjohn, M.D.

USC Department of Orthopaedic Surgery
Center for Arthritis and Joint Replacement Surgery

Patient Medical Health Surgery

Patient Name _____ USC MRN: _____

Age: _____ ☐Male ☐Female DOB: _____

Referring Physician/Individual/Orthopaedic Surgeon (Circle One) _____

Address _____

Phone# _____Fax# _____

Would you like correspondence sent to the above person? ☐Yes ☐No

Reason for Visit (Check all that apply)

Hip Pain	☐Right	☐Left	☐Both
Groin pain	☐Right	☐Left	☐Both
Thigh pain	☐Right	☐Left	☐Both
Knee pain	☐Right	☐Left	☐Both
Neck/Back Pain	☐Neck	☐Mid Back	☐Low Back
Shoulder pain	☐Right	☐Left	☐Both

Duration of Pain/Symptoms

☐Days ☐Weeks ☐Months ☐Years

Onset of Pain

☐Spontaneous ☐Gradual ☐Traumatic

Pain Level (choose one)

☐No pain

☐Mild/Occasional; does not compromise activities; occurs after periods of increased activity

☐Mild with stair climbing

☐Mild with all walking and stair climbing

☐Moderately severe pain, but occasional; forces concessions in daily living;
Requires Tylenol #3, Vicodin, Lortab, Advil, Celebrex, or Vioxx.

☐Moderately severe; continuous pain

☐Severe pain; serious limitations and disabling

☐Severe pain; serious limitations and disabling

Do you have trouble sleeping because of your pain?

☐Never ☐Occasionally ☐Every Night

What makes the pain better? _____

Do you feel that you limp?

☐No Limp ☐Moderate Limp ☐Unable to walk

Do you use any assistive devices (cane, crutches, or walker)?

☐None ☐1 cane for long walks ☐1 cane at all times ☐Walker

☐2 canes ☐1 crutch ☐2 crutches ☐Unable to walk

How far can you walk before your pain stops you?

☐Unlimited walking ☐less than 2 blocks
☐More than 10 blocks/30min ☐indoor only
☐2-10 blocks/15min ☐unable to walk

Do you have any difficult walking stairs?

☐No difficulty. No need for banister. Reciprocal stairs
☐Normal up, difficulty going down
☐Reciprocal stairs (one after another) but nee bannister up or down
☐Much difficulty. One stair at a time and need bannister.
☐Unable to walk stairs

Are you able to put on sock and shoes and tie shoes?

☐With ease ☐With difficulty ☐need help, unable to do alone

How long can you sit comfortably?

☐1 hour in any chair ☐less than 1 hour in raised chair ☐unable

What is your usual mode of transportation?

☐Personal car ☐van ☐city bus ☐medi van ☐ambulance

_____
_____
_____
_____

MEDICAL HISTORY

☐Problems with anesthesia ☐Diabetes
☐History of bleeding disorders ☐Stroke/TIA's
☐High blood pressure/hypertension ☐Hypothyroidism
☐Heart attack/MI/Coronary artery disease ☐Osteoporosis
☐Blood clots in legs or lungs ☐Hepatitis A, B, or C
☐Cancer – Breast, Lung, Prostate, or Colon ☐HIV

SURGICAL HISTORY

Please list dates of procedures, type of procedure, surgeon, and hospital where surgery was performed.

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS ☐None

Please list all medications with dose and frequency and reason for medication

Medicine Dose Frequency Reason Taken

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

☐None ☐Penicillin ☐Sulfa drugs ☐Other

_____

OCCUPATION

_____ ☐Working ☐Retired ☐Disabled

MARITAL STATUS

☐Single ☐Divorced

☐Married ☐Widowed

☐Separated ☐Lives Alone

SMOKING/ALCOHOL CONSUMPTION

☐Smokes, _____ppd

☐Alcohol, _____drinks/day, _____drinks/week

☐None

FAMILY HEALTH HISTORY

Father ☐Living ☐Deceased

_____Age Died of _____

Mother ☐Living ☐Deceased

_____Age Died of _____

Siblings ☐Living ☐Deceased

_____Age Died of _____

Siblings ☐Living ☐Deceased

_____Age Died of _____

DOB:
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REVIEW OF SYSTEMS

Do you have any of the following symptoms, please check all that apply

General health

☐Persistent Fever ☐Chills ☐Weight Gain ☐Weight Loss
☐Nausea ☐Vomiting ☐Fatigue

Head/Ears/Throat

☐Normal ☐Glaucoma ☐Cataracts ☐Sinusitis
☐Headaches ☐Hearing Aids ☐Dental Problems

Pulmonary/Lungs

☐Normal ☐COPD ☐Comments_____
☐Asthma ☐Shortness of breath

Cardiovascular/Heart

☐Normal ☐Chest pain with activity ☐Comments_____
☐Chest pain at rest ☐palpitations prior heart surgery

Neurologic

☐Normal ☐TIA ☐Seizures
☐Stroke ☐Tremor ☐Numbness in hands or feet

Gastrointestinal

☐Normal ☐Ulcers
☐Heartburn ☐Adverse reactions to NSAID's
☐Reflux ☐Bleeding

Urinary Tract

☐Normal ☐Urinary frequency (at night)
☐Pain with voiding (dysuria) ☐Prostate cancer
☐Incontinence ☐BPH

Hematology/Lymph nodes

☐Anemia ☐Bleeding/Clotting disorders ☐Swollen Nodes

Endocrine

☐Diabetes ☐Hypothyroidism ☐Hyperthyroidism

Musculoskeletal

☐Can uses assist devices ☐Perceived leg length difference
☐Neck or back pain ☐right shorter ☐left shorter

Skin

☐Normal ☐Rashes ☐Psoriasis

Psychiatric

☐Depression

DOB:
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Physical Exam

Vital Signs:
☐Ht: _____
☐Wt: _____
☐Pulse: _____
BP: _____

☐**Constitutional**: [Alert oriented, in no apparent distress. He/she is in good spirits and demonstrates appropriate affect]

☐**Gait**: [Normal Coordination]

Trendelenburg / antalgic / ataxic **slight / mild / moderate / severe**

☐**Neck:** [No deformity, symmetric non-painful range of motion. No cervical lymphadenopathy appreciated.]

☐**Spine**: [No deformity, Symmetric range of motion within normal limits.]

☐**Upper extremities**: [No visible deformities, full pain-less range of motion in all joints with good stability. The patient has adequate strength to manage assistive devices.]

☐**Hip:** [No visible deformities noted.]

ROM	R	L
Extension	°	°
Flexion	°	°
ABduction	°	°
ADduction	°	°
Internal Rotation	°	°
External Rotation	°	°
	°	°
Stinchfield	°	°
Greater trochanter tenderness	°	°

DOB:
DOS:
ATT:
FIN:
MRN:

Knees:

☐**ROM**	**RIGHT**	**LEFT**
Extension	°	°
Flexion	°	°
☐**Alignment**	_____ ° varus/valgus	_____ ° varus/valgus
Passively corrects	Y/N/partially	Y/N/partially
☐**Stability**		
Varus/Valgus Stress	Intact/___° varus /___° valgus	Intact/___° varus /___° valgus
Anterior/Posterior Stress		
☐**Effusion**	None/trace/mild/mod/large	None/trace/mild/mod/large
☐**Crepitus**	- / + / ++ ; M/L/PF	- / + / ++ ; M/L/PF
☐**Skin**	Intact/scar(s)/sinus/wound	Intact/scar(s)/sinus/wound

Lower extremities:

☐**Peripheral Pulses**:

Dorsalis pedis: R= 1+/2+/3+ L= 1+/2+/3+

Posterior tibial: R= 1+/2+/3+ L= 1+/2+/3+

☐**Motor**: [5/5 motor strength for bilateral ankle dorsiflexion, plantar flexion, RHL and FHL.]

	Right	**Left**
Ankle Dorsiflexion	1 2 3 4 5 /5	1 2 3 4 5 /5
Ankle plantar flexion	1 2 3 4 5 /5	1 2 3 4 5 /5
EHL	1 2 3 4 5 /5	1 2 3 4 5 /5
FHL	1 2 3 4 5 /5	1 2 3 4 5 /5

☐**Sensory:** [No focal deficits appreciated bilateral lower extremities.]

	Right	**Left**
Medial lower leg	Intact / diminished / absent	Intact / diminished / absent
Lateral lower leg	Intact / diminished / absent	Intact / diminished / absent
Dorsal foot	Intact / diminished / absent	Intact / diminished / absent
Plantar foot	Intact / diminished / absent	Intact / diminished / absent
1st dorsal web space	Intact / diminished / absent	Intact / diminished / absent

☐**Deep tendon reflexes:** [normal patellar tendon reflexes and no Babinski noted bilaterally.]

☐**Skin:** [No visible lesions were appreciated on the upper or lower extremities to suggest inflammatory arthropathy, psoriasis, neoplasia, or inflection.]

DOB:
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ATT:
FIN:
MRN:

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REFERRING OR PRIMARY PHYSICIAN INFORMATION (So that we may mail a copy of your visit):

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

WORK COMP INFO (Please skip this section if not work related):

W/C Carrier: _____

W/C Claims Address: _____

City, State, Zip: _____

Claims Adjuster: _____

Phone Number: _____

Fax Number: _____

Employer: _____

Phone Number: _____

Address: _____

Claim #: _____

Date of Injury: _____

Nurse Case Manager: _____

Phone Number: _____

Fax Number: _____

ATTORNEY INFO:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Primary Treating Physician: _____

Address: _____

City, State, Zip: _____

Secondary Treating Physician: _____

Address: _____

City, State, Zip: _____

☐ Consultation Only ☐ 2nd Opinion Only ☐ Evaluation/Treatment

AUTHORIZED TO TREAT: ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Other: _____

☐ INFORMED TO BRING FILMS ☐ INFORMED TO BRING INTERPRETER

USC ORTHOPAEDIC SURGERY
SURGERY INTAKE FORM

PATIENT ID

DOB:
DOS:
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FIN:
MRN: