

Name: _____ Date: _____

Age: _____ years

Gender: Female Male

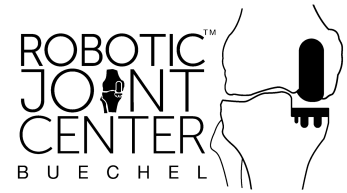
Height: _____ ft. _____ in. (or) _____ cm

Weight: _____ lbs. (or) _____ Kg

Knee Involved: Right: Yes No Left: Yes No

Medical History Form

Robotic Joint Center™
www.RoboticJointCenter.com



Medical History (Check all that apply)

Joint / Extremity History:

History of Blood Clots in Legs: No Yes: Right Left
History of Varicose Veins in Legs: No Yes: Right Left
History of Deep Infection in Knee Joint: No Yes: Right Left
History of Deep Infection in Hip Joint: No Yes: Right Left
History of fracture in Hip: No Yes: Right Left
History of fracture in Thigh Bone: No Yes: Right Left
History of fracture in Leg Bone: No Yes: Right Left
History of fracture in Ankle: No Yes: Right Left

Bleeding Disorders:

None Yes
 Ulcers GI Factor V Leiden Low Platelets Splenectomy
 Liver Cirrhosis Hepatitis Von Willebrand disease Hemophilia A Hemophilia B

Immune Disorders:

None Yes
 Rheumatoid Lupus Other: _____

Diabetes History:

None YES
 Insulin Oral Medication No Medication

Heart Conditions:

None YES
 Hypertension (High Blood Pressure) High Cholesterol Hyperlipidemia
 Heart Attack Atrial Fibrillation Chest Pain Aortic Aneurysm Congestive Heart Failure
 Heart Stents Heart Bypass Pace Maker Valve Replacement Defibrillator

Lung Conditions:

None YES
 Asthma COPD Emphysema History of Pneumonia History of Tuberculosis
 History of Pulmonary Embolism (Blood Clot in the Lung), when _____

Gastro-Intestinal:

None YES
 Gastric Ulcers Diverticulitis Diverticulosis Acid Reflux (GERD)
 Pancreatitis Gall Bladder Disease Liver Disease Chronic Diarrhea Irritable Bowel

Neurologic Conditions:

None YES
 Stroke Cerebral Aneurysm TIA Seizures Migraines Parkinson's Tremors

Kidney/ Urinary:

None YES
 Chronic Urinary Infections Kidney Stones Kidney Failure Incontinence BPH

Thyroid Disease:

None YES
 Hyperthyroid Hypothyroid Parathyroid Disease

Cancer:

None YES
 Prostate Breast Lung Colon Thyroid Lymphoma Leukemia Liver

Skin Disorders:

None YES
 Skin Cancer Melanoma Psoriasis Eczema Bruise Easy Fungal Infections

Allergies (Check all that apply)

- | | | | | | |
|--|--------------------------------------|---|--|---|--------------------------------------|
| <input type="checkbox"/> No Drug Allergies | <input type="checkbox"/> LATEX | <input type="checkbox"/> Nickel | <input type="checkbox"/> Titanium | <input type="checkbox"/> Chrome Cobalt | <input type="checkbox"/> Bone Cement |
| <input type="checkbox"/> Ancef (Cefazolin) | <input type="checkbox"/> Vancomycin | <input type="checkbox"/> Rocephin (ceftriaxone) | <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Doxycycline | |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Augmentin | <input type="checkbox"/> Keflex (Cephalexin) | | |
| <input type="checkbox"/> Sulfa(Bactrim) | <input type="checkbox"/> Levaquin | <input type="checkbox"/> Ciprofloxin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Topical Iodine | |
| <input type="checkbox"/> Iodine Dye (IV) | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Toradol | <input type="checkbox"/> Dilaudid | | |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Percocet | <input type="checkbox"/> Morphine | <input type="checkbox"/> Fentanyl | <input type="checkbox"/> Hydrocodone | |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> NSAIDS | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Bupivacane | <input type="checkbox"/> Cortisone | |
| <input type="checkbox"/> Adhesives | <input type="checkbox"/> Gluten | <input type="checkbox"/> Other Allergies: | _____ | | |

Past Surgical History (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Knee Arthroscopy: | <input type="checkbox"/> right, Date _____ | <input type="checkbox"/> left, Date _____ |
| <input type="checkbox"/> Knee ACL Repair: | <input type="checkbox"/> right, Date _____ | <input type="checkbox"/> left, Date _____ |
| <input type="checkbox"/> Knee Open Meniscectomy: | <input type="checkbox"/> right, Date _____ | <input type="checkbox"/> left, Date _____ |
| <input type="checkbox"/> Knee Replacement: | <input type="checkbox"/> right, Date _____ | <input type="checkbox"/> left, Date _____ |
| <input type="checkbox"/> Hip Replacement: | <input type="checkbox"/> right, Date _____ | <input type="checkbox"/> left, Date _____ |
| <input type="checkbox"/> Leg Artery bypass surgery: | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Varicose Leg Vein Stripping: | <input type="checkbox"/> right | <input type="checkbox"/> left |
| <input type="checkbox"/> Inferior Vena Cava Filter (Greenfield Filter) | | |
| <input type="checkbox"/> Cardiac Stents: | Date: _____ | |
| <input type="checkbox"/> Cardiac Bypass | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Pacemaker |
| | <input type="checkbox"/> Defibrillator | |
| <input type="checkbox"/> Breast Surgery: | <input type="checkbox"/> Lumpectomy: <input type="checkbox"/> right <input type="checkbox"/> left | <input type="checkbox"/> Mastectomy: <input type="checkbox"/> right <input type="checkbox"/> left |
| <input type="checkbox"/> Prostatectomy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Appendectomy |
| | <input type="checkbox"/> Tonsils | <input type="checkbox"/> Gall Bladder |
| | <input type="checkbox"/> Inguinal Hernia | |
| <input type="checkbox"/> Cosmetic Surgery | _____ | |
| <input type="checkbox"/> Other | _____ | |

Social History (Check all that apply)

- Marital Status:**
- Single Married Divorced Widowed
- Children:** None #Boys _____ #Girls _____
- Tobacco Use:** None
- Cigarettes Yes _____ packs/day
- Cigars Pipe Other
- Quit Smoking, Date _____
- Alcohol Use:** None
- _____ # of drinks Day week month
- Type _____
- Working:** Yes No Retired
- Occupation: _____

Family History (Check all that apply)

- | | Father | Mother | Siblings |
|--------------------------|--------------------------|--------------------------|--------------------------|
| Osteoarthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatoid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Deceased? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Activities: _____

Review of Systems (check all that apply)

General Symptoms

- Recent Weight loss Yes No
- Recent Weight Gain Yes No
- Fever Yes No
- Chills Yes No
- Night Sweats Yes No

Eyes, Ears, Nose, Throat

- Blurred Vision Yes No
- Loss of Vision Right Left
- Ringing in ears Yes No
- Loss of hearing Yes No
- Recent Bloody noses Yes No
- Sore Throat Yes No

Cardiovascular System

- Chest pain Yes No
- Palpitations Yes No
- Shortness of Breath Yes No

Pulmonary System

- Cough Yes No
- Shortness of Breath Yes No
- Asthma Yes No

Gastrointestinal System

- Blood in stool Yes No
- Constipation Yes No
- Ulcers Yes No
- Hepatitis Yes No
- Diarrhea Yes No

Urinary Disorders

- Blood in urine Yes No
- Burning Urine Yes No
- Incontinence Yes No
- BPH Yes No

Skin Disorders

- Rashes Yes No
- Bruises Yes No
- Psoriasis Yes No
- Fungal Yes No

Neurologic / Psychiatric

- Depression Yes No
- Anxiety Yes No
- Headaches Yes No
- Stroke Yes No
- TIA Yes No
- Seizures Yes No

Musculoskeletal

- Arthritis Yes No
- Gout Yes No
- Osteoporosis Yes No
- Fractures Yes No

Locations: _____

Medications

Name	Dose	Frequency

Name	Dose	Frequency

By signing this form, I certify the information provided is accurate and correct to the best of my knowledge.

Signature _____ Date _____