Medical History Form

Robotic Joint Center™

Frederick F. Buechel, Jr. MD

Last Name: _____

First Name: _____ **Date**: _____

Age: _____years

Gender: ☐ **Female** ☐ **Male**

Height: _____ft. _____in. (or) _____cm

Weight: _____ lbs. (or) _____Kg

Knee Involved: **Right:** ☐ Yes ☐ No **Left:** ☐ Yes ☐ No

Reset Form Button: ☐

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 Bowl

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)

☐ **No Drug Allergies** ☐ **LATEX** ☐ Nickel ☐ Titanium ☐ Chrome Cobalt ☐ Bone Cement
☐ **Ancef (Cefazolin)** ☐ Vancomycin ☐ Rocephin (ceftriaxone) ☐ Clindamycin ☐ Doxycycline
☐ **Penicillin** ☐ Amoxicillin ☐ Augmentin ☐ Keflex (Cephalexin)
☐ Sulfa(Bactrim) ☐ Levaquin ☐ Ciprofloxin ☐ Erythromycin ☐ Topical Iodine
☐ Iodine Dye (IV) ☐ Shellfish ☐ Toradol ☐ Dilaudid
☐ Codeine ☐ Percocet ☐ Morphine ☐ Fentanyl ☐ Hydrocodone
☐ Aspirin ☐ NSAIDS ☐ Lidocaine ☐ Bupivicane ☐ Cortisone
☐ Adhesives ☐ Gluten ☐ Other Allergies: _____

Past Surgical History (Check all that apply)

☐ Knee Arthroscopy: ☐ right, Date _____ ☐ left, Date _____
☐ Knee ACL Repair: ☐ right, Date _____ ☐ left, Date _____
☐ Knee Open Meniscectomy: ☐ right, Date _____ ☐ left, Date _____
☐ Knee Replacement: ☐ right, Date _____ ☐ left, Date _____
☐ Hip Replacement: ☐ right, Date _____ ☐ left, Date _____
☐ Leg Artery bypass surgery: ☐ right ☐ left
☐ Varicose Leg Vein Stripping: ☐ right ☐ left
☐ Inferior Vena Cava Filter (Greenfield Filter)
☐ Cardiac Stents: Date: _____
☐ Cardiac Bypass ☐ Heart Valve Replacement ☐ Pacemaker ☐ Defibrillator
☐ Breast Surgery: ☐ **Lumpectomy:** ☐ right ☐ left ☐ **Mastectomy**: ☐ right ☐ left
☐ Prostatectomy ☐ Hysterectomy ☐ Appendectomy ☐ Tonsils ☐ Gall Bladder ☐ Inguinal Hernia
☐ Cosmetic Surgery _____
☐ 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: _____

Activities: _____

Family History (Check all that apply)

	Father	Mother	Siblings
Osteoarthritis	☐	☐	☐
Rheumatoid	☐	☐	☐
Osteoporosis	☐	☐	☐
Bleeding Disorder	☐	☐	☐
Alcoholism	☐	☐	☐
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
Hypertension	☐	☐	☐
Heart Attack	☐	☐	☐
Stroke	☐	☐	☐
Deceased?	☐	☐	☐

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	☐ N
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 _____

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