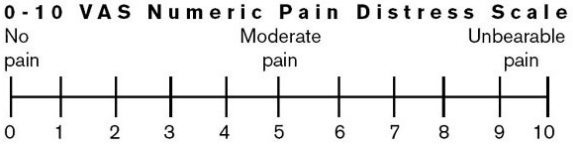
Michael P. Leathers, MD
Orthopaedic Surgeon Specializing in
Sports Medicine/Shoulder, Hip and Knee Reconstruction

HIP AND BACK HISTORY AND PHYSICAL

Name: **Age**: **Date**:

What side is the problem? ☐ Left ☐ Right ☐ Both **What side do you write with?** ☐ Left ☐ Right	**Email Address:**
Height: **Weight:**	

Circle a number from 0-10 that best describes how much pain you are having **RIGHT NOW.**



For a child or non-english speaking adult, use the FACES© pain rating scale below:

Please list any **ALLERGIES** you have to medications or food/substances	☐ None
Please list **prescription medications** on the **ATTACHED** sheet or check "None"	☐ None

Check the Box if you have:	☐ *NONE OF THE BELOW*	
☐ Alcohol Abuse or Dependence	☐ Coronary Artery Disease	☐ MRSA Infection/Colonization
☐ Anemia	☐ Deep Vein Thrombosis	☐ Myocardial Infarction
☐ Asthma	☐ Diabetes Mellitus	☐ Opioid Dependence
☐ Blood Transfusion	☐ Hepatitis	☐ Pulmonary Hypertension
☐ Cancer	☐ HIV/AIDS	☐ Sickle Cell Anemia
☐ CHF	☐ Hypertension	☐ Stroke
☐ Cirrhosis	☐ Kidney Disease	☐ Substance Abuse
☐ Clotting Disorder	☐ Liver Disease	☐ TIA
☐ COPD	☐ Other	☐ Other

Past Medical History:	☐ *NONE OF THE BELOW*	
☐ Allergies	☐ Anesthetic Complications	☐ Ankylosing Spondylitis
☐ Anxiety	☐ Arthritis	☐ Baker's Cyst
☐ Bleeding Disorder	☐ Blood Disorder	☐ Bone Cyst
☐ Bursitis	☐ Carpal Tunnel	☐ Depression
☐ Fibromyositis	☐ Fractures	☐ Ganglion Cyst
☐ GERD	☐ Glaucoma	☐ Heart Disease
☐ Intestinal Disease	☐ Kyphosis	☐ Nerve/Muscle Disease
☐ Osteoarthritis	☐ Osteoporosis	☐ Paget's Disease of Bone
☐ Scoliosis	☐ Seizures	☐ Sinus Disorder
☐ Skin Disease	☐ Spondylolisthesis	☐ Thyroid Disease
☐ Ulcer	☐ Other	☐ Other

Past Surgical History:	Date		Date		Date
☐ Abdomen Surgery		☐ Foot Fracture Surgery		☐ Knee Arthroscopy	
☐ Ankle Fracture Surgery		☐ Foot Surgery		☐ Knee Surgery	
☐ Back Surgery		☐ Hand Surgery		☐ Laminectomy	
☐ Carpal Tunnel Release		☐ Heart Surgery		☐ Shoulder Arthroscopy	
☐ Elbow Fracture Surgery		☐ Hip/Femur Fracture Surgery		☐ Shoulder Surgery	
☐ Elbow Surgery		☐ Humerus Fracture Surgery		☐ Spinal Fusion	
☐ Other		☐ Joint Replacement		☐ Wrist fracture Surgery	

Family History:

☐ Anesthesia Problems	☐ Diabetes	☐ Osteoporosis	☐ Cancer
☐ Lupus	☐ Rheumatoid Arthritis	☐ Clotting Disorders	☐ Osteoarthritis

Physician Signature_____Date_____

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Do you smoke? ☐ Yes ☐ No ☐ Smokeless Tobacco Packs per day: _____ Years of use: _____ Quit Date: _____	**Alcohol Use:** ☐ Yes ☐ No Drinks/Week: _____
History of illegal drug use: ☐ Yes ☐ No Last use date: _____ If yes, what type? _____	

Check and explain if you have any of the following <u>symptoms</u> **CURRENTLY**:

☐ **NONE OF THE BELOW**

☐ Headache, dizziness, visual problems _____
☐ Ear, nose or throat problem _____
☐ Chest pain, irregular heartbeat, palpitations _____
☐ Lung problems, asthma, shortness of breath _____
☐ Difficulty or frequent urination _____
☐ Nausea, vomiting, diarrhea, heartburn _____
☐ Loss of sensation in your arms or legs _____
☐ Vascular disease _____
☐ Diabetes, thyroid or other endocrine problems _____
☐ Easy bruising _____
☐ Fevers, chills, night sweats _____
☐ Recent weight loss or gain _____

When did you start to have pain?

Was there a specific injury (if so, what happened)?

If you have low back pain, do you have worse pain with:

Coughing or sneezing? ☐ Yes ☐ No
Sleeping? ☐ Yes ☐ No

Do you have any bowel problems: ☐ Yes ☐ No

Please list any previous back/hip surgeries below

Where do you feel the pain?

☐ Front of the hip ☐ Back of the hip
☐ Outside of the hip ☐ Lower back

Does the pain shoot down into the foot? ☐ Yes ☐ No
Do you have numbness or tingling in the foot? ☐ Yes ☐ No
Does your hip pop? ☐ Yes ☐ No

What previous treatments have you tried: ☐ None

☐ NSAIDS *(Motrin, Ibuprofen)* Helpful? ☐ Y ☐ N
☐ Narcotics *(Codeine, Vicodin)* Helpful? ☐ Y ☐ N
☐ Physical Therapy Helpful? ☐ Y ☐ N
☐ Injections Helpful? ☐ Y ☐ N
☐ Surgery Helpful? ☐ Y ☐ N

What makes the pain better

What makes the pain worse?

How do you describe the pain?

☐ Dull ☐ Aching ☐ Sharp ☐ Throbbing

Occupation?

What sports/activities do you participate in?

Sport	Level	Hours/Week	Weeks/Year

What questions can I answer for you today?

1. _____
2. _____
3. _____

Physician Signature_____Date_____

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2801 K Street, Suite 330
Sacramento, CA 95816
(916) 732-3000

NAME: _____ DATE: _____

CURRENT MEDICATION SHEET

Please list your medications, including any over the counter medications such as Asprin, Advil, Aleve, Tylenol, etc. Please list all natural vitamins, supplements and herbs that you take.

MEDICATION	DOSE	FREQUENCY (How often you take)

Physician Signature_____Date_____