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*Joint Replacement*
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**Name:** ____________________________ **AGE:** _____________ **DATE:** ________________

-The "BODY PART" identified for today's appointment (please circle what applies for this visit):

Left or Right: Knee—Hip—Shoulder—Elbow—Wrist—Hand
Other: ______________________________________________________________________

-The "BODY PART" was normal until when? ____________________________________________

-Pain level on "1-to-10" scale (Note: "10" is consistent with near LOSS OF CONSCIOUSNESS): _____

-What does your pain keep you from doing? ________________________________________
________________________________________________________________________

**DESCRIBE YOUR PAIN** : (CIRCLE ALL THAT APPLY) :

ACHY…..STABBING…..SHARP…..DULL…..BURNING…..ELECTRICAL

-Do you have mostly pain with walking? ........................................................... **Yes** _____ **No** _____

-Are there other specific features of your pain you can describe? _________________________
________________________________________________________________________

**FOR KNEES ONLY:**

-Do you have swelling? **Yes** _____ **No** _____

-Can you sleep on your side with your knees touching/resting on each other? **Yes** _____ **No** _____

-Does it hurt to "twist" your knee when:
Getting into and out of your car? **Yes** _____ **No** _____
Walking with a sudden "pivot/twist" in one direction or another? **Yes** _____ **No** _____
Tapping something out of your path with a "twist" of your foot? **Yes** _____ **No** _____

-Can you squat? **Yes** _____ **No** _____
What's worse (circle): Going "down" into the squat or coming "up" out of it?

-Does your knee "lock" on you? **Yes** _____ **No** _____
("Locking" is when your knee is straight & you can't bend it…or visa/versa)
-Does it "give-way?" **Yes** _____ **No** _____
Describe: ______________________________________________________________

**NAME:** ______________________________ **AGE:** ____________ **DATE:** ________________

-Can you go "up" & "down" stairs/slopes? **Yes** _____ **No** _____

What's worse (circle): going "up" or going "down"

With stairs, must you take "one-at-a-time?" **Yes** _____ **No** _____

Must you hold onto the railing for support? **Yes** _____ **No** _____

**FOR HIPS ONLY :**

-Where is your pain located? Front (groin area)…..Side…..Low back area

Describe : ________________________________________________________________

____________________________________________________________________________

-Are you unable to do any of the following activities:

Bend forward to touch your toes? **Yes** _____ **No** _____

Put your shoes and socks on? **Yes** _____ **No** _____

Cross affected leg over the other? **Yes** _____ **No** _____

Sleep on the affected side? **Yes** _____ **No** _____

-Does your pain radiate:

Down into your knee(s)? **Yes** _____ **No** _____

Below the knee and into your foot ? **Yes** _____ **No** _____

**IN GENERAL :**

-Have you or any of your family members ever been tested/treated for any of the following:

Rheumatoid Arthritis? **Yes** _____ **No** _____

Gout? **Yes** _____ **No** _____

Lupus? **Yes** _____ **No** _____

Other? **Yes** _____ **No** _____

-Are you or have you ever taken medicine to decrease your pain? **Yes** _____ **No** _____

If so, please list: ______________________________________________________

-Do you take the supplement, *Glucosamine & Chondroitin*? **Yes** _____ **No** _____

-Do you have any allergies/sensitivities to specific food groups or products? **Yes** _____ **No** _____

If so, please list: ______________________________________________________

-Have you ever taken steroids or had medications injected into your joints? **Yes** _____ **No** _____

*If so, which joint and when, then, how much pain relief did you get (circle)?

None…..25% 50% 75% 95%..............

Product injected and approximate date(s): ____________________________________

**IF OVER THE AGE OF 50:**

-Have you ever had a DEXA or bone density test? **Yes** _____ **No** _____

If so, where & when was your last exam ? ____________________________________

-Have you ever been told you have 'Osteoporosis' or 'Osteopenia?' **Yes** _____ **No** _____

-Are you losing height ? **Yes** _____ **No** _____

-Do you take medicine, hormones or calcium supplements specifically for your bones? **Yes** _____ **No** _____

If so, what and for how long? ______________________________________________