



13177

·Please check any of the following conditions you have or have had in the past.
·If you are unsure, please ask a staff member to assist you in filling out this form.

You may check more than one condition.

Medical Condition History Check this box if you have **no** medical problems no medical problems

- Alcoholism
- Anemia
- Anxiety
- Asthma
- Arthritis - rheumatoid (verified with blood test)
- Arthritis - osteo, degenerative
- Blood Clot Year
- Blood Transfusion Year
- Bowel disease
- Cancer (specify) _____
- Cardiac Arrhythmia (Abnormal heart rate)
- Congestive Heart Failure
- Coronary Artery Disease (Angina)
- Cerebrovascular Disease (Stroke)
- COPD (Chronic Obstructive Pulmonary Disease)
- Diabetes
- Depression
- Fibromyalgia
- GERD
- Gout
- Heart Attack Year
- Hypertension (High Blood Pressure)
- Hypercholesterolemia (Elevated Cholesterol)
- Hypothyroidism
- Kidney Disease
- Liver Disorder - Cirrhosis
- Liver Disorder - Hepatitis
- Lung Disease
- Osteomyelitis
- Parkinson's
- Ulcer Disease
- Other (specify all other) _____

Surgery/ Procedures These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

Have you ever had surgery? Yes No

Year

Ear, Nose, Throat Surgeries

- Deviated Septum -----
- Sinus Repair -----
- Tonsillectomy -----
- Tracheostomy -----
- Vocal Cord Surgery -----

Gastrointestinal Surgeries

- Appendectomy -----
- Cholecystectomy (Gallbladder removed) -----
- Colon Resection -----
- Exploratory Laparoscopy -----
- Hernia -----
- Femoral Incisional Inguinal Umbilical
- Liver Resection -----
- Small Bowel Obstruction Repair -----
- Splenectomy -----

Gynecologic Surgeries

- Hysterectomy -----
- Oophorectomy -----
- Ruptured ectopic -----
- Laparoscopy -----
- C-Section -----

Urologic Surgeries

- Bladder Suspension -----
- Bladder Removed -----
- Lithotripsy (Stone Machine) -----
- Prostatectomy (Prostate Removed) -----
- Vasectomy -----

General Surgeries

- Breast Biopsy -- Right Left Bilateral -----
- Mastectomy -- Right Left Bilateral -----
- Thyroid Surgery -----
- Whipple -----

Heart (Cardiac) Surgeries

- CABG_ # arteries 1 2 3 4 4+ -----
- Valve -- Aortic Mitral Tricuspid -----
- Angioplasty -----
- Defibrillator -----
- Pace Maker -----

Vascular Surgeries

- Bypass Graft - Legs -----
- Vascular Access -----
- AAA -----
- Thoracic Aneurysm -----

Thoracic Surgeries

- Chest Tube -----
- Pulmonary -----
- Pectus -----

Neurosurgeries

- Brain Tumor ----- Malignant Benign -----
- Brain Aneurysm -----
- Chiari Decompression -----
- Spinal Cord Tumor_ Malignant Benign -----
- Epidural Injection -----
- Abscess -----
- Stent -----



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Orthopaedic Surgery/ Procedures

Please check any procedures you have had and give the year.

Most Recent Year

Previous Surgery Year

(if same surgery performed more than once)

Broken Bones/Fracture Repair Surgeries

- Fracture Repair - Finger ----- Right Left Bilateral -----

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- Fracture Repair - Hand ----- Right Left Bilateral -----

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- Fracture Repair - Wrist ----- Right Left Bilateral -----

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- Fracture Repair - Arm ----- Right Left Bilateral -----

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- Fracture Repair - Elbow ----- Right Left Bilateral -----

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- Fracture Repair - Shoulder ----- Right Left Bilateral -----

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- Fracture Repair - Hip/Pelvis ----- Right Left Bilateral -----

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- Fracture Repair - Femur ----- Right Left Bilateral -----

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- Fracture Repair - Knee ----- Right Left Bilateral -----

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- Fracture Repair - Lower Leg ----- Right Left Bilateral -----

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- Fracture Repair - Ankle/Foot ----- Right Left Bilateral -----

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Ankle/Foot Surgeries

- Ankle Arthroscopy ----- Right Left Bilateral -----

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- Ankle Fusion ----- Right Left Bilateral -----

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- Tendon Surgery ----- Right Left Bilateral -----

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- Toe Surgery specify _____ ----- Right Left Bilateral -----

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Elbow, Wrist, Hand Surgeries

- Biceps Repair ----- Right Left Bilateral -----

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- Carpal Tunnel Surgery ----- Right Left Bilateral -----

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- Elbow Arthroscopy ----- Right Left Bilateral -----

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- Elbow Ligament Reconstruction ----- Right Left Bilateral -----

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- Elbow Replacement ----- Right Left Bilateral -----

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- Hand Tendon Repair ----- Right Left Bilateral -----

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- Nail Bed Surgery ----- Right Left Bilateral -----

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- Tennis Elbow Surgery ----- Right Left Bilateral -----

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- Trigger Finger Surgery ----- Right Left Bilateral -----

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- Wrist Ligament Reconstruction ----- Right Left Bilateral -----

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Knee Surgeries

- Knee Arthroscopy ----- Right Left Bilateral -----

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- Cartilage surgery/meniscus surgery ----- Right Left Bilateral -----

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- Knee replacement ----- Right Left Bilateral -----

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- Ligament reconstruction - ACL ----- Right Left Bilateral -----

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- Ligament reconstruction - other ----- Right Left Bilateral -----

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Hip Surgeries

- Hip replacement ----- Right Left Bilateral -----

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- AVN Surgery Core Decompression Fibular Graft Right Left Bilateral -----

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Shoulder Surgeries

- Shoulder Arthroscopy ----- Right Left Bilateral -----

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- Rotator cuff surgery ----- Right Left Bilateral -----

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- Shoulder replacement ----- Right Left Bilateral -----

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- Shoulder stabilization ----- Right Left Bilateral -----

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Spine Surgeries

- Laminectomy ----- Cervical Lumbar Thoracic -----

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- Anterior Fusion ----- Cervical Lumbar Thoracic -----

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- Posterior Fusion ----- Cervical Lumbar Thoracic -----

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- Posterior Discectomy ----- Cervical Lumbar Thoracic -----

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Other (List all other surgeries) _____



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Hand Dominance: Right Left Use both equally**Lower Extremity Function Scale**How would you rate your lower extremity today as a percentage of normal (0% - 100%, with 100% being normal)? %We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.**Today, do you or would you have any difficulty at all with:** (check one number for each line)

Activities	Extreme difficulty or unable to <u>perform activity</u>	Quite a bit <u>of difficulty</u>	Moderate <u>difficulty</u>	A little bit <u>of difficulty</u>	<u>No difficulty</u>
a. Any of your usual work, housework, or school activities	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
b. Your usual hobbies, recreational or sporting activities	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
c. Getting into or out of the bath	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
d. Walking between rooms	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
e. Putting on your shoes or socks	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
f. Squatting	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
g. Lifting an object, like a bag of groceries from the floor	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
h. Performing light activities around your home	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
i. Performing heavy activities around your home	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
j. Getting into or out of a car	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
k. Walking 2 blocks	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
l. Walking a mile	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
m. Going up or down 10 stairs (about 1 flight of stairs)	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
n. Standing for 1 hour	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
o. Sitting for 1 hour	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
p. Running on even ground	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
q. Running on uneven ground	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
r. Making sharp turns while running fast	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
s. Hopping	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
t. Rolling over in bed	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

Please rate the severity of the following symptoms in the last week (check number)

	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Extreme</u>
Leg, foot or ankle pain	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Leg, foot or ankle pain when you performed any specific activity	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Tingling (pins and needles) in your leg, foot or ankle	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Weakness in your leg, foot or ankle	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Stiffness in your leg, foot or ankle	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

During the past week, how much difficulty have you had sleeping because of pain in your leg, foot or ankle?	<u>No difficulty</u>	<u>Mild difficulty</u>	<u>Moderate difficulty</u>	<u>Severe difficulty</u>	<u>So much difficulty that I can't sleep</u>
	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5



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SF-12 - Check ONLY ONE answer for each question

Instructions: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:

- 1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

(#2 and #3) The following items are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

- | | <u>Yes,</u>
Limited
A Lot | <u>Yes,</u>
Limited
A Little | <u>No, Not</u>
Limited
At All |
|--|---------------------------------|------------------------------------|-------------------------------------|
| 2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Climbing several flights of stairs | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

(#4 and #5) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 4. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 5. Were limited in the kind of work or other activities | <input type="radio"/> 1 | <input type="radio"/> 2 |

(#6 and #7) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 6. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 7. Didn't do work or perform other activities as carefully as usual | <input type="radio"/> 1 | <input type="radio"/> 2 |

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- 1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

(#9, #10 and #11) These questions are about how you feel and how things have been with you during the past 4 weeks.

For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks

- | | <u>All</u>
of the
<u>time</u> | <u>Most</u>
of the
<u>time</u> | <u>A good</u>
bit of
<u>time</u> | <u>Some</u>
of the
<u>time</u> | <u>A little</u>
of the
<u>time</u> | <u>None</u>
of the
<u>time</u> |
|---|-------------------------------------|--------------------------------------|--|--------------------------------------|--|--------------------------------------|
| 9. Have you felt calm and peaceful? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 10. Did you have a lot of energy? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 11. Have you felt downhearted and blue? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |

12. During the past 4 weeks, how much of the time has your physical or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)?

- | <u>All</u>
of the
<u>time</u> | <u>Most</u>
of the
<u>time</u> | <u>Some</u>
of the
<u>time</u> | <u>A little</u>
of the
<u>time</u> | <u>None</u>
of the
<u>time</u> |
|-------------------------------------|--------------------------------------|--------------------------------------|--|--------------------------------------|
| <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |

PLEASE RETURN THIS COMPLETED PACKET TO THE FRONT DESK NOW