

DR. HALAWI – NEW PATIENT QUESTIONNAIRE (PROSTHETIC KNEE)

Patient Name: _____ Date: _____

Please fill the following as completely as possible. If you are unsure about a certain item, please check with the medical assistant when you are boarded in the room.

CHIEF COMPLAINT:

Specify in your own words why you are here today: _____

HISTORY OF PRESENT ILLNESS:

Age: ___ years

Side of pain: ___ Left ___ Right ___ Left and Right

What part of the knee hurts? ___ Inside ___ Outside ___ Front ___ Behind ___ Everywhere

Duration of symptoms: ___ days or ___ months or ___ years

Pain is rated as 1 2 3 4 5 6 7 8 9 10 out of 10 (10 is your worst pain)

Pain is described as ___ Sharp ___ Burning ___ Grinding ___ Aching ___ Other (specify) _____

Pain occurs ___ With activity ___ Without activity ___ With and without activity

Pain is ___ Constant ___ Intermittent ___ Occasional

Pain interferes with: ___ Activities of daily living ___ Work activities ___ Recreational activities

___ Ability to stay fit and healthy ___ Other (specify) _____

Pain is relieved with ___ No relieving factors ___ Ambulatory device ___ Rest ___ Repositioning

___ Prescription medications (specify) _____

___ Over-the-counter medications (specify) _____

___ Other (specify) _____

Was there a specific incident that brought about your pain? ___ No ___ Yes (specify) _____

Assistive devices: ___ None ___ Walker ___ Cane ___ Crutches ___ Wheelchair

Numbness or tingling in feet? ___ No ___ Yes

Pain radiating to the foot? ___ No ___ Yes

Worker's compensation? ___ No ___ Yes (specify date of injury) _____

How were you referred to Dr. Halawi? _____

Regarding your painful knee replacement:

When was your knee replaced? _____

Who was your surgeon? _____

Were you ever happy with your prosthetic knee? ___ No ___ Yes (specify duration) _____

Did you have any wound healing problem or prolonged drainage? ___ No ___ Yes (specify) _____

How long did you stay in the hospital after the initial knee replacement? _____

Were you ever re-admitted to the hospital since your initial knee surgery? _____

Since your knee replacement, did you have additional surgery on the same knee? ___ No ___ Yes (specify) ___

Since your knee replacement, have you had any invasive procedures elsewhere in your body (example: dental work, endoscopy, etc.)? ___ No ___ Yes (specify) _____

My knee pain is associated with ___ Weight bearing only, ___ Rest only, ___ Rest and weight bearing

___ Other (specify) _____

Does the knee make noise? ___ No ___ Yes

Do you have feeling that your knee is not stable ___ No ___ Yes (specify) _____

What is the worst activity for your knee? _____

Do you have other replaced joints? ___ No, ___ Yes (specify) _____

MA use only: BMI _____ HbA1C (with date if diabetic) _____

PAST MEDICAL HISTORY:

Check all that apply to you and specify.

Musculoskeletal: ___ Loose joints, ___ Gout, ___ Bone and Joint Infections, ___ Back pain
___ Inflammatory arthritis (psoriasis, rheumatoid, etc.).

Cardiovascular: ___ Heart failure, ___ Atrial fibrillation, ___ Coronary bypass or aortic valve replacement

Gastrointestinal: ___ Acid reflux, ___ Stomach ulcers, ___ Liver disease

Genitourinary: ___ Recurrent urinary infections, ___ Kidney disease/failure

Respiratory: ___ Emphysema, ___ Chronic obstructive pulmonary disease, ___ Obstructive sleep apnea

Psychiatric: ___ Depression, ___ Anxiety

Skin: ___ Chronic rash, ___ Active rash, ___ Poor healing

Endocrine: ___ Diabetes.

Hematology: ___ Blood clots, ___ Bleeding disorder, ___ Cancer, ___ Blood thinners other than baby aspirin

Allergy/immunology: ___ Organ transplant, ___ Immunosuppressive therapy, ___ Allergy to metals
___ Allergy to antibiotics (if yes, specify antibiotic and reaction)

Neurologic: ___ Seizure disorder, ___ Stroke

Infectious: ___ HIV, ___ Hepatitis

Dental: ___ Gum disease, ___ Tooth extractions, ___ Poor dentition

Other: ___ Prescription narcotic medications, ___ Pain management contract

SOCIAL HISTORY:

What is your occupation? _____

Current residence: ___ Home ___ Assisted living ___ Nursing home

If residence is home, who lives with you? _____

Caregiver Assistance: ___ Not Required ___ Required

Smoking: ___ No, ___ Yes (specify amount) _____, ___ quit (specify when) _____

Alcoholic drinking: ___ No, ___ Yes (specify daily amount) _____

FAMILY HISTORY:

Has anyone in your immediate biological family (parents, siblings, children) had either metal allergy, blood clots, or bleeding disorders? ___ No, ___ Yes (specify) _____

SURGICAL HISTORY:

Do you have other joint replacement? ___ No, ___ Yes (specify) _____