

Patient Hip Replacement History and Physical Form

Patient Name: _____ DOB: _____

Surgery Right Left Total Hip Date of Surgery: _____

Symptoms

How long has your hip been hurting? _____

How far can you walk pain free? _____

- Yes No Does your hip wake you up at night?
- Yes No Can you spend 2 hours on your feet and be pain free?
- Yes No Do you have pain in your groin?
- Yes No Do you have pain in your thigh?
- Yes No Have you lost motion in your hip?
- Yes No Can you tie your own shoes with ease?
- Yes No Can you go up or down stairs pain free?
- Yes No Can you squat?
- Yes No Can you walk on uneven ground without pain?

- Yes No Do you have back pain?
- Yes No Do you have numbness in your legs?
- Yes No Do you have pain below your knee?
- Yes No Do you have pain in your gluteal region?

Treatment

- Yes No Over the counter medication
- Yes No Taken herbal medication
- Yes No Prescription anti-inflammatories
- Yes No Have you used a cane or walker?
- Yes No Have you had surgery on your hip?

Please fill out form on the back side

Patient History and Physical Form

Patient Name: _____

Age: _____

| Allergy to any medication | |
|---------------------------|----------|
| Medication | Reaction |
| | |
| | |
| | |
| | |
| | |

- Yes No Do you smoke
- Yes No Kidney disease
- Yes No Liver disease
- Yes No Any bleeding disorders
- Yes No Diabetes
- Yes No Thyroid disease
- Yes No Reflux / GERD
- Yes No Stomach ulcers
- Yes No Rheumatoid disease
- Yes No Cancer of any kind
- Yes No Infection that put you in the hospital

Yes No Do you have a sensitive to metals?

What medications to you take regularly? Include herbal medicine also. Include a second sheet if needed.

| Medication | Reason for taking |
|------------|-------------------|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| Past Surgeries | Year |
|----------------|------|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Do you suffer from any of the health conditions listed below?

- Yes No High blood pressure
- Yes No Had a Heart Attack
- Yes No Have a pacemaker or defibrillator
- Yes No Have an irregular heart beat
- Yes No Had a blood clot
- Yes No Stroke / Mini Stroke
- Yes No Chronic swelling in your legs
- Yes No Asthma
- Yes No COPD

Yes No Have you had problems with anesthesia before?

Any additional conditions or comments: _____



OrthoWest

Orthopedic & Sports Medicine Specialists
2725 S 144 St Suite 212
Omaha, NE 68144
(402) 637-0800

Please return these forms back to OrthoWest before your up coming joint replacement. This can be done one of three ways:

- Mail the forms to back to OrthoWest
- Fax the forms to 637-0846
- Return the forms with you when you see Dr Neumann back in the office before your surgery.

If you have any questions please contact our office

Brian Fontana PA-C