DR. HALAWI – NEW PATIENT QUESTIONNAIRE (PROSTHETIC HIP)

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:
Your age: ___ years
Side of pain: ___ Left ___ Right ___ Left and Right (if both, specify which hip is worse ___Right, ___ Left)
Pain is located in the ___ Buttocks ___ Side ___ Groin ___ Lower back ___ Other (specify) _____
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 (specify side) _____
Pain radiating from hip to foot? ___ No ___ Yes (specify side) _____
Worker's compensation? ___ No ___ Yes (specify date of injury) _____
How were you referred to Dr. Halawi? _____

Regarding your painful hip replacement:
When was your hip replaced? _____
Who was your hip surgeon? _____
Were you ever happy with your prosthetic hip? ___ No ___ Yes (specify duration) _____
Did you have any wound healing problem or prolonged drainage? ___ No ___ Yes (specify) _____
Were you ever re-admitted to the hospital since your initial hip surgery? _____
Since your hip replacement, did you have additional surgery on the same hip? ___ No ___ Yes (specify) _____
Since your hip replacement, have you had any surgeries elsewhere in your body? ___ No ___ Yes (specify) _____
My hip pain is associated with ___ Weight bearing only, ___ Rest only, ___ Rest and weight bearing
___ Other (specify) _____
Does the hip make noise? ___ No ___ Yes
Did your hip ever dislocate since surgery? ___ No ___ Yes
Do you have feeling of your hip is not stable? ___ No ___ Yes (specify) _____
Do you feel like your legs are not of equal length? ___ No ___ Yes (specify) _____
What is the worst activity for your hip? _____
Do you have other replaced joints? ___ No, ___ Yes (specify) _____

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

REVIEW OF SYSTEMS:

Check all that apply to you and specify.

Musculoskeletal: ___ Loose joints, ___ Gout, ___ Bone and Joint Infections, ___ Back pain
___ Psoriasis, lupus, rheumatoid, other inflammatory conditions (specify) _____

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, ___ Bipolar disorder

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

Endocrine: ___ Diabetes, ___ Hypothyroidism

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

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

Neurologic: ___ Seizure disorder, ___ Stroke, ___ Multiple sclerosis, ___ Parkinson's

Infectious: ___ HIV, ___ Hepatitis, ___ MRSA infection or colonization

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

Opioids: ___ 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, ___ Occasional/Social, ___Daily

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) _____