



15060

·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 -----



15060

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

<input type="checkbox"/> Fracture Repair - Finger	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Hand	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Wrist	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Arm	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Elbow	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Shoulder	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Hip/Pelvis	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Femur	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Knee	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Lower Leg	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Fracture Repair - Ankle/Foot	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Ankle/Foot Surgeries

<input type="checkbox"/> Ankle Arthroscopy	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ankle Fusion	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Tendon Surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Toe Surgery specify _____	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Elbow, Wrist, Hand Surgeries

<input type="checkbox"/> Biceps Repair	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Carpal Tunnel Surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Arthroscopy	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Ligament Reconstruction	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Elbow Replacement	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Hand Tendon Repair	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Nail Bed Surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Tennis Elbow Surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Trigger Finger Surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Wrist Ligament Reconstruction	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Knee Surgeries

<input type="checkbox"/> Knee Arthroscopy	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Cartilage surgery/meniscus surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Knee replacement	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ligament reconstruction - ACL	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Ligament reconstruction - other	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Hip Surgeries

<input type="checkbox"/> Hip replacement	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> AVN Surgery <input type="radio"/> Core Decompression <input type="radio"/> Fibular Graft	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Shoulder Surgeries

<input type="checkbox"/> Shoulder Arthroscopy	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Rotator cuff surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Shoulder replacement	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Shoulder stabilization	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Spine Surgeries

<input type="checkbox"/> Laminectomy	-----	<input type="checkbox"/> Cervical	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Thoracic	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Anterior Fusion	-----	<input type="checkbox"/> Cervical	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Thoracic	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Posterior Fusion	-----	<input type="checkbox"/> Cervical	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Thoracic	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				
<input type="checkbox"/> Posterior Discectomy	-----	<input type="checkbox"/> Cervical	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Thoracic	-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>					-----	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>				

Other (List all other surgeries) _____

Harris Hip

Please answer the following questions to the best of your ability. Select the one answer that best describes your situation. Check **ONLY ONE** answer for each question. If you have any questions, the nurse will be happy to assist you.

How would you rate your hip today as a percentage of normal (0% - 100%, with 100% being normal)? %

A. Hip Evaluation

1. Pain **Please describe your pain** none slight mild moderate marked totally disabled

B. Function**1. Limp**

Please describe your limp

- I have no limp
 I have a slight limp
 I have a moderate limp
 I have a severe limp
 I am unable to walk

2. Support

Please describe the assistance you require

- none
 I use a cane for long walks
 I use a cane full time
 I use one crutch
 I use two canes
 I use two crutches/walker
 I am unable to walk

3. Distance Walked

Please describe the distance you are able to walk

- I am not limited in the distance I can walk
 I am limited in the distance I can walk to 6 blocks
 I am limited in the distance I can walk to 2-3 blocks
 I am limited to walking only indoors
 I am limited to walking to the bed and chair

C. Activities**1. Stairs**

Please describe your ability to climb stairs

- I am able to climb stairs normally
 I am able to climb stairs normally with the use of a banister
 I climb stairs with any method
 I am unable to climb stairs

2. Socks/Tie Shoes

Please describe your ability to put on shoes and socks

- I am able to put on shoes/socks with ease
 I am able to put on shoes/socks with difficulty
 I am unable to put on shoes/socks

3. Sitting

Please describe your ability to sit

- I can sit in any chair up to 1 hour
 I can sit in a high chair for 1/2 hour
 I am unable to sit in any chair for 1/2 hour

4. Public Transportation

Please describe your ability to use public transportation

- I am able to enter public transportation
 I am unable to enter public transportation

Have you had hip replacement surgery? No Yes

If you have had hip replacement surgery please answer the next 2 questions

Overall, what is your level of satisfaction with Hip replacement surgery?

- Extremely satisfied
 Very satisfied
 Moderately satisfied
 Slightly satisfied
 Not at all satisfied

If you could, would you choose again to have this surgery performed on your Hip? No Yes



15060

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