MR#: ☐☐☐☐☐☐☐
Name of Patient:
Date of Birth:
Place Label Here

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

OPD PROGRESS RECORD

ORTHOPAEDIC OUTPATIENT SERVICE

Today's Date: ____________________ **Patient's Name:**____

Birth Date:____________________**Age:**_________

Thank you for completing this questionnaire. This information will assist your doctor and the outpatient staff to evaluate and treat your problem. This questionnaire is confidential and will be made a part of your medical record.
Please bring this questionnaire and any X-rays, other imaging and/or test reports to your appointment.

Name of person completing the form, if not the patient:_____________________________________

Relationship to the patient: _____________________________________

Referring MD: _____________________________________

Address:_____________________________________ Phone:_________________

Primary Care physician, if different than referring physician:_____________________________

Address:_____________________________________ Phone:_________________

State your main complaint or problem:_____________________________________

____

When did your problem begin? _____________________________________

How did your problem start? (If injury, please describe): _____________________________

____

Is this a work-related injury/Worker's Compensation? ❒ YES ❒ NO

Have you seen another doctor or Orthopaedic surgeon for this problem? ❒ YES ❒ NO

If YES, what was the diagnosis? _____________________________________

Describe any treatments, up to now, with dates: _____________________________

____

____

Where is your pain? _____________________________________

What other symptoms? _____________________________________

Is the problem getting better, worse or staying the same? (circle one)

What makes it worse?_____________________________________

What makes it better? _____________________________________

What **can't** you do because of this problem? _____________________________

____

What is the quality of your pain? (circle any that apply)

Aching Burning Numbing Pins & Needles Sharp/Stabbing Radiating Other: ___________________

How many hours a day do you have this pain? _______

Does the pain radiate to anywhere else? ❒ YES ❒ NO If YES, where? _______________

Please rate your pain level:

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

No Pain Most Severe Pain

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PAST MEDICAL HISTORY:

Have you ever had or do you now have:

_______ High blood pressure
_______ Diabetes or problem with sugar
_______ Blood clots in your blood stream
_______ Asthma, or hay fever with wheezing
_______ Tuberculosis
_______ Cancer. Where?____

_______ Arthritis
_______ Gout
_______ Osteoporosis
_______ Seizures/Epilepsy
_______ Sickle Cell Anemia

Other Disease of your:

_______ Lungs
_______ Blood
_______ Liver
_______ Kidney
_______ Heart

List any other medical conditions we should know about: ____

____

List all your current Medications:

Name	Dose	How Often
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

List all your current Allergies to:

Medications	Reaction	Other	Reaction
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Do you have or suspect Latex Sensitivity? Yes _________No _________

Have you ever had a Blood Transfusion? Yes _________No _________

When? ___________________________ Why?___________________________

When did you last have a Tetanus shot? Date_______________________________________

Have you ever had Problems with Anesthesia? Yes ______No ______If yes, describe: ____________________

____

Please list all surgeries you have had and the dates:

____

____

____

Please list all injuries, broken bones, etc., with dates and treatments:

____

____

Have you ever sought treatment for stress or have you ever been treated for a psychological disorder?______________

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OPD PROGRESS RECORD

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FAMILY MEDICAL HISTORY:

	If alive:					**If deceased:**
Father:	Age:________________	HEALTH: (circle one)	good	fair	poor	Age:________________
	Cause of poor health:______________________________					Cause:______________
Mother:	Age:________________	HEALTH: (circle one)	good	fair	poor	Age:________________
	Cause of poor health:______________________________					Cause:______________
Siblings:	Age:________________	HEALTH: (circle one)	good	fair	poor	Age:________________
	Cause of poor health:______________________________					Cause:______________
	Age:________________	HEALTH: (circle one)	good	fair	poor	Age:________________
	Cause of poor health:______________________________					Cause:______________
	Age:________________	HEALTH: (circle one)	good	fair	poor	Age:________________
	Cause of poor health:______________________________					Cause:______________
	Age:________________	HEALTH: (circle one)	good	fair	poor	Age:________________
	Cause of poor health:______________________________					Cause:______________

Have your blood relatives had any of the following? (circle):

High blood pressure Heart disease Heart attack Stroke Diabetes Tuberculosis Epilepsy Alcoholism
Cancer Kidney disease Rheumatic fever Bleeding tendency Arthritis and/or Gout Asthma Dropsy
Nervous breakdown

SOCIAL BACKGROUND:

Handedness: ❒ Right ❒ Left ❒ Ambidextrous

Are you a smoker? Yes ___ No ___ Substance:___________________ Amount: __________How long:_________

Have you used street drugs? Yes ____ No ____ Substance:_______________________________How long:_________

Do you drink alcohol? Yes ___ No ___Substance:_________________________________ Drinks/week: ___________

Highest education: ____

Have you ever lived outside the United States? Yes ____ No ____

If yes, where and for how long? ____

Are you: Single _______ Married_______ Divorced _______ Widowed______ Domestic Partner________

Number of children:_________________ and their ages:____

If not Married or with a Partner, do you live alone? Yes ___ No ____

If No, who lives with you? ____

Type of Residence: House____________ Apartment________ Other:_____________________________________

Does your Residence have Stairs/Steps? Yes ___ No If yes, approximately how many steps?___________________

Currently employed: Yes _____ No_____ If not, when did you last work?___________________________________

Current occupation? ____

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OPD PROGRESS RECORD
ORTHOPAEDIC OUTPATIENT SERVICE

COMPLETE REVIEW OF SYSTEMS
Do you now have or recently had:

CONSTITUTIONAL

YES	NO	HOW LONG?	
❒	❒	________	Fever or Chills (circle which one)
❒	❒	________	Easily fatigued
❒	❒	________	Unexplained weight loss/gain
❒	❒	________	Unexplained decreased appetite
❒	❒	________	Nausea or Vomiting

CARDIOVASCULAR

YES	NO	HOW LONG?	
❒	❒	________	Chest pain or Angina
❒	❒	________	Heart murmur
❒	❒	________	Irregular heart rate
❒	❒	________	Poor blood circulation
❒	❒	________	Leg/ankle swelling

ALLERGY/IMMUNOLOGY

YES	NO	HOW LONG?	When exposed to allergens, do you get:
❒	❒	________	Sneezing, runny nose or Itching eyes
❒	❒	________	Hives or itchy rash
❒	❒	________	Difficulty breathing or swallowing
❒	❒	________	Are you allergic to metals? ____________
❒	❒	________	Do you get sick or get infections frequently?

NEUROLOGICAL

YES	NO	HOW LONG?	
❒	❒	________	Seizures or Tremor
❒	❒	________	Frequent headaches/migraines
❒	❒	________	Feeling faint or dizzy
❒	❒	________	Numbness or loss of sensation
❒	❒	________	Tingling or pain that radiates

HEMATOLOGIC/LYMPHATIC

YES	NO	HOW LONG?	
❒	❒	________	Previous Deep Vein Thrombosis (leg clot)
❒	❒	________	Previous Pulmonary Embolism (lung clot)
❒	❒	________	Bleeding problems
❒	❒	________	Easy bruising
❒	❒	________	Enlarged lymph nodes (neck/arm pit/groin)

GASTROINTESTINAL

YES	NO	HOW LONG?	
❒	❒	________	Diarrhea or Constipation
❒	❒	________	Abdominal pain
❒	❒	________	Leakage of bowel
❒	❒	________	Bloody stool

EARS, NOSE, MOUTH, THROAT

YES	NO	HOW LONG?	
❒	❒	________	Loss of hearing
❒	❒	________	Nasal problems
❒	❒	________	Toothache/Bleeding gums/Sores
❒	❒	________	Difficulty swallowing or eating

MUSCULOSKELETAL

YES	NO	HOW LONG?	
❒	❒	________	Difficulty moving any limb
❒	❒	________	Muscle wasting or Weakness
❒	❒	________	Swelling. Where? ________________
❒	❒	________	One limb smaller/larger than the other

RESPIRATORY

YES	NO	HOW LONG?	
❒	❒	________	Shortness of breath/difficulty breathing
❒	❒	________	Cough
❒	❒	________	Coughing up blood
❒	❒	________	Do you have a cold?

GENITOURINARY

YES	NO	HOW LONG?	
❒	❒	________	Pain when you urinate
❒	❒	________	Frequent urination
❒	❒	________	Unable to control urination
❒	❒	________	Blood in urine

SKIN

YES	NO	HOW LONG?	
❒	❒	________	Rashes or Sores
❒	❒	________	Slow to heal when injured
❒	❒	________	Lesions changing in size, shape or color

EYES

YES	NO	HOW LONG?	
❒	❒	________	Recent change of vision

Other eye problem________________________________

MENTAL

YES	NO	HOW LONG?	
❒	❒	________	Depression
❒	❒	________	Anxiety
❒	❒	________	Insomnia

ENDOCRINE

YES	NO	HOW LONG?	
❒	❒	________	Excessive thirst or hunger
❒	❒	________	Cold or heat intolerance
❒	❒	________	Night sweats

Reviewed by: ________________________________ Date:______________
Physician's Signature

____
Printed Name

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OPD PROGRESS RECORD

ORTHOPAEDIC OUTPATIENT SERVICE

Please answer these questions so that we may evaluate your condition and offer you high quality care.

I am being seen for my:

❒ HIP: ❒ Right ❒ Left ❒ Both Sides

❒ KNEE: ❒ Right ❒ Left ❒ Both Sides

1. Describe your pain when you are walking.
○ None/Or I ignore it
○ Mild/Occasional or intermittent
○ Mild/With stairs only
○ Mild/With stairs and level ground walking
○ Moderate/Pain comes and goes
○ Moderate/Pain every day
○ Severe/Constant, disabling pain

2. How often do you have pain?
○ Never
○ Only occasionally or intermittently
○ Only when I first get up from sitting
○ Only when standing
○ Only with walking more than 30 minutes
○ Anytime I walk
○ At all times

3. Describe your pain when you are at rest.
○ None
○ Mild
○ Moderate
○ Severe

4. If you have pain in your HIP, where do you feel it? *Check all that apply.*
○ In the groin
○ In the front of the thighs
○ On the side of my hip
○ In the buttock
○ Not applicable – No pain

5. If you have pain in your KNEE, where do you feel it? *Check all that apply.*
○ In the front of the knee
○ In the inner side of the knee (medial)
○ In the outer side of the knee (lateral)
○ In the back of the knee
○ In the entire knee area
○ Not applicable – No pain

6. Which is your current activity level?
○ I am bedridden or confined to a wheelchair.
○ I am sedentary with minimal capacity for walking or other activity.
○ I perform light labor, such as house cleaning, yard work, assembly line work, or light sports.
○ I perform moderate manual labor, such as lifting heavy weight, participating in moderate sports like walking, swimming and bicycling.
○ I participate in heavy manual labor. I frequently lift heavy weight and participate in vigorous sports, such as running, tennis and racquetball.

7. Do you need assistance in getting out of bed?
○ I can get out of bed on my own.
○ I need the assistance of another person.

8. What is your current work capacity?
○ 100% of normal
○ 75% of normal
○ 50% of normal
○ 25% of normal
○ 0% of normal

9. How do you put on your shoes and socks?
○ With no difficulty
○ With slight difficulty
○ With extreme difficulty
○ I am unable to do it without assistance

10. How do you go up and down the stairs?
○ Normally (1 foot on each step)
○ Normally, but I require the use of the rail
○ I take them 1 step at a time (2 feet on each step)
○ I can go up the stairs with difficulty using some other method
○ I am unable to go up and down the stairs

11. How do you stand up from a sitting position?
○ I can arise from a chair without using my arms
○ I have to use my arms to help me get out of my chair
○ I cannot get up from a chair without assistance from another person

(questions continue on next page)

MR#: ☐☐☐☐☐☐☐
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12. Do you need support when walking?
○ I walk without any support
○ I use one cane when I go on a long walk
○ I use one cane most of the time
○ I use one crutch
○ I use two canes
○ I use two crutches
○ I use a walker
○ I am unable to walk

13. How long can you walk <u>without</u> support? (i.e., without cane, crutches or walker)
○ I can walk an unlimited amount of time, more than 60 minutes, without support
○ I can only walk 31-60 min without support
○ I can only walk 11-30 min without support
○ I can only walk 2-10 min without support
○ I can only walk less than 2 min without support
○ I am unable to walk without support

14. How long can you walk <u>with</u> support?
○ Unlimited, greater than 60 minutes with support
○ 31-60 min with support
○ 11-30 min with support
○ 2-10 min with support
○ Less than 2 minutes with support
○ I am unable to walk
○ Not applicable/I can walk without support.

15. How far can you walk without stopping?
○ I can walk unlimited distances
○ I can walk only 6 blocks
○ I can walk only 2-3 blocks
○ I can walk only indoors
○ I am confined to a wheelchair or a bed

16. How long can you sit in a chair?
○ I am comfortable sitting in any chair 1 hour or longer
○ I am only comfortable sitting in a high chair for 30 minutes or less
○ I am unable to sit comfortably in any chair

17. How easily can you get in and out of a car?
○ It is easy
○ It is difficult
○ I am unable to get in and out of a car

18. Can you utilize public transportation?
○ Yes
○ No

19. Does the hip/knee pain interfere with sleeping?
○ Yes
○ No

20. Does the hip/knee pain interfere with sexual activity?
○ Yes
○ No

21. What medication are you currently taking for your hip/knee?
○ None
○ Anti-inflammatory medicine, such as aspirin, Advil, or Ibuprofen
○ Steroid medication
○ Narcotic medication
○ Other medication ___________________________

22. Do you often have pain in any joints besides your painful hip/knee?
On same side of painful hip/knee:
- ○ Shoulder
- ○ Elbow
- ○ Hand/Wrist
- ○ Hip
- ○ Knee
- ○Ankle/Foot

On other non-painful side:
- ○ Shoulder
- ○ Elbow
- ○ Hand/Wrist
- ○ Hip
- ○ Knee
- ○Ankle/Foot

○ Low Back Pain
○ None