DEARBORN
& ASSOCIATES
INSTITUTE FOR JOINT RESTORATION

Name:____ Date of Birth:________________ Height________Weight_______

Marital Status: Single Married Divorced Widowed Separated

Referred by:____Faith Tradition:___________________________________

Occupation:_______________________ Employer_______________________________________ Currently working? Yes/No

Primary Care Physician (PCP) Name: ____Date of last visit:__________________

Address: ____PCP Phone #_____________________Fax#______________________

Are you currently receiving care from any other doctors or health care professionals (e.g., cardiologist, nephrologist, pulmonologist, oncologist, pain specialist, endocrinologist, etc.)?

Provider's Name and Specialty	Provider's Phone Number

Which pharmacy do you use for prescription medications? Please provide the name and phone number.

____

Please list every operation you've had under anesthesia, including the year, surgeon's name and hospital (if possible):

____

____

____

Yes No *Do you have allergies to medications, latex, or food*? If yes, please list and state the reaction: _________

____

Yes No *Have you taken steroids (Cortisone, Prednisone) in the past? When:*_____________________________________

Yes No *Do you have history of smoking?* How many years did you smoke:____________Year Quit:_____________

Yes No *Do you drink alcohol?* How often:______________________________Amount:__________________________

Yes No *Do you use recreational or street drugs?* Which ones:_______________________Frequency:_____________

Yes No *Have you been recently hospitalized?* Reason:____

Yes No *Do you have a history of depression?*

Yes No *Have you or any members of your family had problems with anesthesia?* Please describe:_____________

____

Yes No *Do you have loose teeth, caps or dentures?* Please describe:____

Yes No *Do you have known Sleep Apnea?*

Yes No *Do you have a CPAP or BIPAP Machine?*

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Please list all your current prescription/non-prescription medications (you may attach a separate list). Medications include: prescriptions, vitamins, inhalers, supplements, herbal/folk remedies and other non-prescription drugs.

Drug Name	Dose/Amount Taken	Frequency/Time of Day	Reason

Do you now have, or have you ever had, the following medical problems (please circle)?

Heart Attack/Heart Failure? Years(s): ______________
History of Congenital Long QT Syndrome
Chest Pain, pressure, squeezing
AICD/Pacemaker ***(please bring card to appointment)***
Arrhythmia/Palpitations/Irregular Heartbeat
Heart Murmur/Mitral Valve Prolapse
High Cholesterol
High/Low Blood Pressure
Family History of Heart Disease
Stroke/Mini Stroke? Year(s): ______________________
Asthma/Wheezing
Pneumonia/Bronchitis/Chronic Cough
Oxygen Use? Flow rate/route: __________________
Tuberculosis/Night Sweats/Fevers
Cold or Flu within last two weeks
Thyroid Disease
Seizures/Epilepsy

Diabetes? Managing Doctor: ___________________________
Circle Type: Diet Controlled Tablet Insulin
Chronic Kidney Disease? Stage: ________________________
Liver Disease: Hepatitis/Jaundice
Anemia
Blood Disorders/Diseases: ______________________________
Neck/Back Pain/Disc Disease
Lupus (SLE)/Multiple Sclerosis
Polio/Spinal Cord Injury
COPD/Emphysema
Jaw Problems/TMJ
Headaches/Migraines
Prostate Disorder
Use Birth Control Pills
Pregnant? Last Menstrual Period: ________________________
Hiatal Hernia/Ulcers/Acid Reflux

Other: ____

Family History

Do/did any of your brothers, sisters or parents have any of the following? Please list relation and date(s).

Rheumatoid Arthritis__________________________________
Other Joint problems__________________________________
Bleeding problems____________________________________
Anesthesia problems__________________________________
Mental Illness____

Heart Attack ____
Cancer____
Diabetes____
Stroke____
Thyroid Disease______________________________________

Social History

*How many people live in your household (including you)?*_______
*How are they related to you?*____
Do you have stairs at your home? Yes No Inside Outside

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