Study Title: Prospective Orthopaedic Outcomes Study
Lead Researcher: Peter R. Cavanagh, PhD, DSc

Study ID: | | | | | | |

DEMOGRAPHICS

Date of Birth: | | | | | | | | | Age: | | years

Gender: | | Male — Height: | | inches
| | Female — Weight: | | lbs

Handed: | | Right — BMI: | |
| | Left
| | Ambidextrous

Race: | | African American / African Heritage
choose only one | | American Indian or Alaskan Native
| | Asian - Central / South Asian Heritage
| | Asian - East Asian Heritage
| | Asian - Japanese Heritage
| | Asian - South East Asian Heritage
| | Native Hawaiian or Other Pacific Islander
| | White - Arabic / North African Heritage
| | White / Caucasian / European Heritage

Ethnicity: | | Hispanic or Latino
| | Not Hispanic or Latino

Marital Status: | | Single
| | Married
| | Domestic Partner
| | Widowed
| | Other _____

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MEDICAL HISTORY

Social History

Tobacco Use:

mark only one:	Packs per day:	Years:	Types:	Date Quit:
☐ Never	☐ 0.5	☐ 5	☐ Cigarettes	
☐ Quit	☐ 1	☐ 10	☐ Pipe	
☐ Passive	☐ 1.5	☐ 15	☐ Cigars	
☐ Yes	☐ 2	☐ 20	☐ Snuff	
	☐ ____	☐ ____	☐ Chew	

Alcohol Use:

☐ No
☐ Yes

Drinks per week:

☐ Can(s) of beer
☐ Drink(s) containing 0.5 oz of alcohol
☐ Glass(es) of wine
☐ Shot(s) of liquor

Drug Use:

	Use per week:	
☐ No	☐	1
☐ Yes	☐	2
IV Drug Use:	☐	5
☐ No	☐	10
☐ Yes	☐	_____

Are you currently working? ☐ Yes ☐ No

What is or was your occupation? _____

Is this a work-related problem? ☐ Yes ☐ No

If yes, list your OWCP Claim # _____ or L&I Claim # _____

If disabled, when did you last work? _____

Is a lawyer invovled with this problem? _____ If Yes, name/address: _____

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MEDICAL HISTORY CONTINUED

Family History

Please check if any of your family members have had the following:

- ☐ ADHD
- ☐ Alcohol / Drug
- ☐ Allergic /Atopic Disease
- ☐ Arthritis
- ☐ Autoimmune
- ☐ Cancer
- ☐ Colorectal Cancer
- ☐ Diabetes
- ☐ Gastrointestinal (GI)
- ☐ Genitourinary (GU)
- ☐ Heart
- ☐ Hypertension
- ☐ Lipids
- ☐ Osteoporosis
- ☐ Psych
- ☐ Pulmonary
- ☐ Stroke
- ☐ Thyroid
- ☐ Other: _____

Past Medical History

Do you have, or are you being treated for, any of the following (please check all that apply):

- ☐ Allergic rhinitis
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar
- ☐ Bleeding/clotting disorder
- ☐ Cancer
- ☐ Chemical dependency
  - ☐ Drug
  - ☐ Alcohol
- ☐ Chronic lung disease/emphysema (COPD)
- ☐ Congestive heart Failure (CHF)
- ☐ Coronary artery disease (CAD)
- ☐ Depression
- ☐ Diabetes
  - ☐ Using insulin (IDDM)
  - ☐ Not using insulin (NIDDM)
- ☐ Fibromyalgia
- ☐ Heartburn
- ☐ Reflux (GERD)
- ☐ Heart attack (MI)
- ☐ Hepatitis _____ (please specify type(s))
- ☐ High blood pressue (HTN)
- ☐ High cholesterol
- ☐ Psoriasis
- ☐ Rheumatoid Arthritis (RA)
- ☐ Stroke
- ☐ Transient ischemic attack (TIA)
- ☐ Thyroid disorder
  - ☐ Hypo
  - ☐ Hyper
- ☐ Sleep Apnea
- ☐ Other sleep disorder
- ☐ Ulcers
  - ☐ Stomach ulcers
  - ☐ Peptic ulcer disease (PUD)
- ☐ Other (specify) _____
- ☐ **NO PAST MEDICAL HISTORY**

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MEDICAL HISTORY CONTINUED

Allergies

1. Do you have any allergies? ☐ Yes ☐ No If yes, please list.
   To Medications? _____
   To Foods? _____
2. Are you allergic to latex? ☐ Yes ☐ No
3. Are you allergic to iodine? ☐ Yes ☐ No

Medications

1. Are you taking any pain medications? ☐ Yes ☐ No If yes, please list all.

Pain Medications	Dose	Times per day	Reason for taking

2. All other Medications

	Dose	Times per day	Reason for taking

Study ID: | | | | | | |

MEDICAL HISTORY CONTINUED

Review of Systems

Do you or have you had any of the following problems? (check all that apply)				Comments
General	☐	weight gain	☐ insomnia	
	☐	weight loss	☐ fever	
	☐	fatigue	☐ night-sweats/chills	
Eye	☐	glasses/contacts	☐ glaucoma	
	☐	cataracts		
Ear/Nose/Throat	☐	sinus trouble	☐ ringing in ears	
	☐	hearing loss		
Heart/Vascular	☐	myocardial infarction (MI)	☐ high blood pressure	
	☐	congestive heart failure (CHF)	☐ irregular heartbeat	
	☐	peripheral vascular disease	☐ chest pain	
	☐	coronary disease	☐ fluttering in chest	
Lung	☐	shortness of breath	☐ lung disease	
	☐	difficulty breathing	☐ persistent cough	
	☐	chronic obstructive pulmonary disease (COPD)	☐ emphysema	
Stomach/Liver	☐	decreased appetite	☐ diarrhea	
	☐	constipation	☐ hepititis	
	☐	heartburn	☐ Cirrhosis	
	☐	nausea		
Muscles/Bones	☐	arthritis	☐ sprains	
	☐	fractures		
Urinary Tract	☐	kidney stone	☐ prostate problems	
	☐	bladder/kidney infections	☐ painful urinating	
Skin	☐	masses	☐ non-healing wounds	
	☐	blisters	☐ dermatitis	
Neurology	☐	seizures	☐ numbness	
	☐	tingling	☐ severe headaches	
	☐	balancing problems	☐ strokes / TIAs	
Mental Health	☐	anxiety	☐ dementia	
	☐	depression	☐ other (please describe)	
Endocrine	☐	diabetes - diet controlled	☐ increased thirst	
	☐	diabetes - oral medication	☐ thyroid	
	☐	diabetes - using insulin		
Blood/Lymph	☐	bleeding problems	☐ enlarged lymph nodes	
	☐	clotting problems	☐ lymphoma	
	☐	anemia	☐ leukemia	
Immunological	☐	HIV/AIDS	☐ hay fever	
	☐	Sjogrens	☐ lupus	
	☐	scleroderma		
Cancer	☐	under treatment	☐ metastatic	Location:
	☐	currently disease free		

Study ID: | | | | | | |

MEDICAL HISTORY CONTINUED

Surgical History

What studies have you had for this problem? (check all that apply)

- ☐ X-rays
- ☐ CT
- ☐ MRI
- ☐ Arthrogram
- ☐ Nerve Study (EMG)
- ☐ Bone Scan
- ☐ Other: _____

Have you had any previous surgeries for this problem? ☐ Yes ☐ No

Surgeries for this problem	Did it help	Surgeon	Year

List all Other Orthopaedic Surgeries [Bone/Joint/Ligament/Soft Tissue]

Surgeries	Year

Please list/check all Other Surgeries

Surgeries	Year
☐ **No previous surgeries**	
☐ Appendix (appendectomy)	
☐ Gall bladder (cholecystectomy)	
☐ Bypass/open heart (CABG)	
☐ Hernia repair	
☐ Hysterectomy	
☐ Tonsils removed (tonsillectomy)	

Other Surgeries	Year

Study ID: | | | | | | |

MEDICAL HISTORY

Chief Complaint:

History of Present Illness

Location - where is the problem located?

- ☐ Right Side
- ☐ Left Side
- ☐ Both Sides
- ☐ Neck
- ☐ Spine
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist / Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle / Foot
- ☐ Other _____

Severity - please rate the intesnity of your joint pain/discomfort: (1 = no pain, 10 = severe pain)

1 2 3 4 5 6 7 8 9 10

Context - how did this problem begin?

_____

_____

Modifying Factors

What makes your symptom(s) worse?

- ☐ Using affected side
- ☐ Work
- ☐ Exercise
- ☐ Don't know
- ☐ _____

What improves your symptoms?

- ☐ Rest
- ☐ Ice
- ☐ Heat
- ☐ Exercise
- ☐ NSAIDS (anti-inflammatories)
- ☐ _____

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TREATMENT AND STATUS

Primary Procedure	Secondary Procedure
Procedure:	Procedure:
date:	date:
Surgeon:	Surgeon:
Reason/Mechanism:	Reason:
Patient Notes: wound complications: infection: physical therapy: other relevant:	Patient Notes: wound complications: infection: physical therapy: other relevant:
Weight Bearing: (status/time)	Weight Bearing: (status/time)
Function:	Function:
Narcotics Rx: Yes No	Narcotics Rx: Yes No
when off:	when off:
Return to Work:	Return to Work:
Workers' Compensation Status:	Workers' Compensation Status:
Follow-up Imaging: Yes No	Follow-up Imaging: Yes No