



Johns Hopkins Orthopaedics & Spine Surgery at Good Samaritan Hospital

New Joint Patient Questionnaire

Date: _____ Orthopaedic Surgeon: _____

Patient's Name: _____ GENDER: Female Male
(Last) (First) (MI)

Social Security #: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient's E-mail: _____ Married Single Widowed

Employer: _____ Occupation: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone Number: _____

(Please do not leave the following fields blank.)

Referring Physician Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

Primary Care Physician Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

How did you hear about us?

- Physician Seminar Newspaper Television Friend/Relative
 Internet Our Website Google Other _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

Insurance Cert. #: _____ Plan Type: _____ Group #: _____

Guarantor/Member's Name: _____

Guarantor's relationship to patient: Husband Wife Parent

Subscriber's Social Security Number: _____ Date of Birth: _____

Address (on back of card): _____

SECONDARY INSURANCE: _____

Insurance Cert. #: _____ Plan Type: _____ Group #: _____

Guarantor/Member's Name: _____

Guarantor's relationship to patient: Husband Wife Parent

Subscriber's Social Security Number: _____ Date of Birth: _____

Address (on back of card): _____

***PLEASE* circle/answer the following questions so that we may serve you better.**

PAST MEDICAL HISTORY

BRAIN

- TIA (transient ischemic attack)
- Stroke

ENDOCRINE

- Insulin dependent diabetes
- Non-insulin dependent diabetes
- Hypercholesterolemia
- Hypothyroidism
- Severe Osteoporosis

HEART

- Coronary artery disease
- Myocardial infarction (heart attack)
- Hypertension/High Blood Pressure

INFECTIOUS

- HIV
- Hepatitis
- Cellulitis
- Syphilis
- Joint infection

KIDNEY

- Chronic renal failure

LUNG

- Pulmonary embolism
- Chronic bronchitis
- Asthma
- COPD

MUSCULOSKELETAL

- Low back pain
- Sciatica
- Spinal Stenosis
- Degenerative disk disease
- Juvenile Rheumatoid Arthritis
- Lupus
- Rheumatoid Arthritis
- Psoriasis
- Osteoarthritis
- Severe Osteoporosis

CANCER

Type: _____

PSYCHIATRIC

- Alcohol abuse
- Major depression
- Anxiety disorder
- Bipolar disorder
- Schizophrenia

STOMACH AND INTESTINE

- GERD/Reflux
- Gastric ulcer
- Irritable Bowel Syndrome

VASCULAR

- DVT
- Phlebitis
- Sickle cell anemia

OTHER:

1. _____
2. _____
3. _____

PAST ORTHOPAEDIC SURGICAL HISTORY					
PAST SURGERIES	SIDE/LOCATION			Year	NAME OF SURGEON
JOINT REPLACEMENT <input type="checkbox"/> Total Hip Replacement <input type="checkbox"/> Total Knee Replacement <input type="checkbox"/> Partial Knee Replacement <input type="checkbox"/> Core Decompression <input type="checkbox"/> High Tibial Osteotomy	<u>Right</u>	<u>Left</u>	<u>Both</u>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
SPINE <input type="checkbox"/> Cervical (neck) Fusion <input type="checkbox"/> Cervical Disc Removal/Decompression <input type="checkbox"/> Lumbar (lower back) Fusion <input type="checkbox"/> Lumbar Disk Removal/Laminectomy <input type="checkbox"/> Thoracic (mid back) <input type="checkbox"/> Kyphoplasty <input type="checkbox"/> Tumor/Infection	Levels _____	Levels _____	Levels _____	_____	_____
	Levels _____	Levels _____	Levels _____	_____	_____
	Levels _____	Levels _____	Levels _____	_____	_____
	Levels _____	Levels _____	Levels _____	_____	_____
	Levels _____	Levels _____	Levels _____	_____	_____
	Levels _____	Levels _____	Levels _____	_____	_____
SPORTS <input type="checkbox"/> Knee Arthroscopy <input type="checkbox"/> Shoulder Arthroscopy <input type="checkbox"/> Rotator Cuff Repair <input type="checkbox"/> Total Shoulder Replacement <input type="checkbox"/> Other	<u>Right</u>	<u>Left</u>	<u>Both</u>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
TRAUMA (List bone/joint and treatment) _____ _____	<u>Right</u>	<u>Left</u>	<u>Both</u>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

OTHER PAST SURGICAL HISTORY		
<u>BREAST</u> <input type="checkbox"/> Lumpectomy (<i>left or right side</i>) <input type="checkbox"/> Mastectomy (<i>left or right side</i>)	<u>GASTROINTESTINAL</u> <input type="checkbox"/> Hernia repair <input type="checkbox"/> Resection of large bowel <input type="checkbox"/> Removal gall bladder	OTHER: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____
<u>CARDIOVASCULAR</u> <input type="checkbox"/> Pacemaker <input type="checkbox"/> Coronary artery Bypass <input type="checkbox"/> Valve replacement	<u>VASCULAR</u> <input type="checkbox"/> Abdominal aortic aneurysm <input type="checkbox"/> Femoral Bypass <input type="checkbox"/> Dialysis shunt <input type="checkbox"/> Varicose vein stripping	

ALLERGIES

NO KNOWN ALLERGIES

<u>MEDICINE</u>	<u>REACTION</u>	<u>GENERAL</u>	<u>REACTION</u>
<input type="checkbox"/> Aspirin	_____	<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Erythromycin	_____	<input type="checkbox"/> Adhesive	_____
<input type="checkbox"/> NSAIDs	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Penicillin	_____		
<input type="checkbox"/> Sulfa	_____		

MEDICATION INFORMATION

(Please circle the medications you are taking.)

High Blood Pressure:

- Accupril (Quinapril)
- Atenolol
- Capoten (Captopril)
- Cardizem (Diltiazem)
- Cardura (Doxazosin)
- Cozaar (Losartan)
- Diovan (Valsartan)
- Vasotec (Enalapril)
- Zestril (Lisinopril)
- Lopressor/Toprol (Metoprolol)
- Lotensin (Benazepril)
- Norvasc (Amlodipine)
- Procardia (Nifedipine)

Heart Medication:

- Lanoxin (Digoxin)
- Nitroglycerin

Blood Thinners:

- Aspirin
- Coumadin (Warfarin)
- Plavix

OTHER MEDICATION(S):

Cholesterol Lowering Drugs:

- Lipitor (Atrovastatin)
- Pravachol (Pravastatin)
- Zocor (Simvastatin)

Diuretics (Water Pills):

- Dyazide (HCTZ + Trimterrene)
- Lasix (Furosemide)
- Hydrochlorothiazide (HCTZ)

Diabetes:

- Glucophage (Metformin)
- Glucotrol (Glipizide)
- Insulin (Humulin)

Gastrointestinal (Stomach):

- Nexium (Esomeprazole)
- Prevacid (Lansoprazole)
- Prilosec (Omeprazole)
- Zantac (Ranitidine)

Rheumatology:

- Methotrexate
- Plaquenil
- Prednisone

NSAIDs:

- Advil/Motrin (Ibuprofen)
- Aleve (Naproxen or Naprosyn)
- Bextra
- Celebrex
- Mobic

Pain:

- Davocet (Acetaminophen + Propoxyphene)
- Dilaudid
- Duragesic Patch (Fentanyl Patch)
- Endocet/Percocet/Tylox (Oxycodone + Acetaminophen)
- Lortab/Vicodin (Hydrocodone + Acetaminophen)
- MS Contin
- Neurontin
- Neurontin
- Oxycodone/Oxycontin
- Tylenol #3 (Acetaminophen + Codeine)
- Ultram (Tramadol)

FAMILY HISTORY

<input type="checkbox"/> Cancer	<input type="checkbox"/> Other
_____	_____
type	
<input type="checkbox"/> Heart Disease	
_____	_____
type	
<input type="checkbox"/> Diabetes	
_____	_____
Type	

SOCIAL HISTORY

Occupation:

- Employed
- Unemployed
- Student
- Work from home
- Retired

Marital Status:

- Single
- Married
- Separated
- Divorced
- Widowed

Athletics:

- Professional
- Amateur
- Recreational
- None
- Sport _____

Exercises:

- Daily
- Weekly
- Rarely
- Never
- Type _____

SMOKING HISTORY

_____ I have never smoked.

Do you currently smoke? No Yes How long have you smoked? _____

I currently smoke: ¼ pack, ½ pack, ¾ pack, 1 pack 2 packs per day.

I quit smoking: less than 1 year ago more than 1 year ago more than 5 years ago

I formerly smoked: ¼ pack, ½ pack, ¾ pack, 1 pack 2 packs per day.

What type of tobacco did you smoke: Cigarettes Cigars Pipe

ALCOHOL HISTORY

Do you currently drink alcohol? No Yes If yes, what type of alcoholic beverages do you usually drink?
 Beer Wine Hard Liquor (such as whiskey, scotch, gin or vodka)

I CURRENTLY DRINK

- Less than one per month
- 2-4 times per month
- 2-3 times a week
- 4-5 times a week
- 6 or more times a week

I USED TO DRINK

- Less than one per month
- 2-4 times per month
- 2-3 times a week
- 4-5 times a week
- 6 or more times a week

How many drinks did you have on a typical day when you are/were drinking?

- 1-2 drinks
- 3-4 drinks
- 5-6 drinks or more

OTHER SUBSTANCES

_____ I have never used drugs

Do you currently use recreational drugs? No Yes

Have you used: Marijuana Cocaine Heroin Other _____

Have you ever developed an addiction to pain medicine? No Yes

REVIEW OF SYSTEMS

Please mark any symptoms that you are currently experiencing.

GENERAL

- Good general health
- Chills
- Feeling tired all the time
- Dizziness
- Loss of appetite
- Fever
- Night sweats
- Weight gain of more than 10 lbs
- Weight loss of more than 10 lbs

SKIN

- No problems
- Dryness
- Excessive sweating
- Rash

HEENT

- Blurry vision
- Sinusitis
- Fainting
- Headache

NECK

- Difficulty swallowing

RESPIRATORY

- Chest pain
- Shortness of breath
- Chronic cough
- Wheezing

CARDIOVASCULAR

- Chest pain
- Swelling in legs
- Night cramps
- Palpitations
- Phlebitis
- Skipped heartbeats

GASTROINTESTINAL

- Anorexia
- Constipation
- Diarrhea
- Heartburn

MALE GENITOURINARY

- Hesitancy
- Incontinence

NEUROLOGICAL

- Dizziness
- Headaches
- Incontinence stool
- Incontinence urine
- Loss of balance

PSYCHIATRIC

- Anxiety
- Change in sleep pattern
- Depression

ENDOCRINE

- Frequent urination
- Appetite changes
- Cold intolerance

HEMATOLOGY

- Anemia
- Easy bruising
- Enlarged lymph nodes
- Prolonged bleeding
- Spontaneous bleeding

SUMMARY

- All Other Systems Negative

MAJOR COMPLAINT (Please circle which side):

HIP
{ Right Left}

KNEE
{ Right Left}

LEG
{ Right Left}

ANKLE
{ Right Left}

Location of Pain:

- Groin
- Buttocks
- Inside of thigh
- Front of thigh
- Outside of thigh

Location of Pain:

- All over
- Inside
- Front
- Outside
- Along prior scar
- Back of knee

Location of Pain:

- All over
- Outside
- Inside
- Thigh
- Calf

Location of Pain:

- All over
- Outside
- Inside
- Top
- Bottom

FOOT
{ Right Left}

SHOULDER
{ Right Left}

WRIST
{ Right Left}

HAND
{ Right Left}

Location of Pain:

- All over
- Outside
- Inside
- Top
- Bottom

Location of Pain:

- Outside
- Inside
- Front
- Back

Location of Pain:

- All over
- Outside
- Inside
- Top

Location of Pain:

- All over
- Fingers
- Palm
- Back of hand

SYMPTOMS:

Date of Onset: _____ **Duration of symptoms:** 1-7 Days 1-4 Weeks 4-8 Weeks
 8-12 Weeks Other _____ Months/Years

Are Your Symptoms A Result of:

- Fall
- Injury
- Fracture
- Auto Accident
- Sports Injury
- Work
- Other (please describe): _____

Symptoms Increased in: Frequency Intensity or Both

- 1-7 Days ago
- 1-4 Weeks ago
- 1-6 Months ago
- 6-12 Months
- Year or more

Do you wear a brace?: _____ No _____ Yes, if so what type: _____

Have you received physical therapy? No _____ Yes _____ If yes, was it: Helpful Not Helpful

Please Mark All The Tests You Have Had Done For This Problem:

- | | | |
|-----------------|----------------------------|-----------------|
| ___ X-Rays | ___ Mylogram | ___ Injections |
| ___ MRI | ___ CT Scan | ___ Blood Tests |
| ___ Sonogram | ___ Fluid Analysis | ___ EMG |
| ___ Nerve Tests | ___ Bone Scan | |
| ___ Arthrogram | ___ Diagnostic Arthroscopy | |

OTHER: _____

PAIN:

<p>Pain On Weight-Bearing:</p> <input type="checkbox"/> None <input type="checkbox"/> Rarely <input type="checkbox"/> Slight <input type="checkbox"/> Intermittently <input type="checkbox"/> Mild <input type="checkbox"/> Continuous <input type="checkbox"/> Moderate <input type="checkbox"/> Totally Disabled <input type="checkbox"/> Severe	<p>Pain During Rest:</p> <input type="checkbox"/> None <input type="checkbox"/> Rarely <input type="checkbox"/> Slight <input type="checkbox"/> Intermittently <input type="checkbox"/> Mild <input type="checkbox"/> Continuous <input type="checkbox"/> Moderate <input type="checkbox"/> Totally Disabled <input type="checkbox"/> Severe	<p>Night Pain:</p> <input type="checkbox"/> None <input type="checkbox"/> Rarely <input type="checkbox"/> Slight <input type="checkbox"/> Intermittently <input type="checkbox"/> Mild <input type="checkbox"/> Continuous <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<p>Quality of Pain</p> <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing <input type="checkbox"/> Dull <input type="checkbox"/> Constant <input type="checkbox"/> Burning <input type="checkbox"/> Intermittent	<p>Symptoms Improved By:</p> <input type="checkbox"/> Nothing <input type="checkbox"/> Heat <input type="checkbox"/> Walking <input type="checkbox"/> Ice <input type="checkbox"/> Rest <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Brace/Sling <input type="checkbox"/> Medication	<p>Symptoms Worsened By:</p> <input type="checkbox"/> Walking <input type="checkbox"/> Using Stairs <input type="checkbox"/> Standing <input type="checkbox"/> Lifting <input type="checkbox"/> Sitting <input type="checkbox"/> Carrying <input type="checkbox"/> Physical Therapy

<p>WALKING DISTANCE:</p> <table> <tr> <th style="text-align: left;"><u>With Support</u></th> <th style="text-align: left;"><u>Without Support</u></th> </tr> <tr> <td>___ Unlimited</td> <td>___ Unlimited</td> </tr> <tr> <td>___ More than 1 mile</td> <td>___ More than 1 mile</td> </tr> <tr> <td>___ ½ to 1 mile</td> <td>___ ½ to 1 mile</td> </tr> <tr> <td>___ ¼ to ½ mile</td> <td>___ ¼ to ½ mile</td> </tr> <tr> <td>___ 1 Block</td> <td>___ 1 Block</td> </tr> <tr> <td>___ Less than 1 block</td> <td>___ Less than 1 block</td> </tr> <tr> <td>___ Indoors only</td> <td>___ Indoors only</td> </tr> <tr> <td>___ Unable to walk</td> <td>___ Unable to walk</td> </tr> </table>	<u>With Support</u>	<u>Without Support</u>	___ Unlimited	___ Unlimited	___ More than 1 mile	___ More than 1 mile	___ ½ to 1 mile	___ ½ to 1 mile	___ ¼ to ½ mile	___ ¼ to ½ mile	___ 1 Block	___ 1 Block	___ Less than 1 block	___ Less than 1 block	___ Indoors only	___ Indoors only	___ Unable to walk	___ Unable to walk	<p>STAIR CLIMBING:</p> <input type="checkbox"/> Normal <input type="checkbox"/> Holding on with one hand <input type="checkbox"/> Holding with both hands <input type="checkbox"/> Climb one step at a time <input type="checkbox"/> Unable to climb stairs
<u>With Support</u>	<u>Without Support</u>																		
___ Unlimited	___ Unlimited																		
___ More than 1 mile	___ More than 1 mile																		
___ ½ to 1 mile	___ ½ to 1 mile																		
___ ¼ to ½ mile	___ ¼ to ½ mile																		
___ 1 Block	___ 1 Block																		
___ Less than 1 block	___ Less than 1 block																		
___ Indoors only	___ Indoors only																		
___ Unable to walk	___ Unable to walk																		
<p>LIMP:</p> <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe																			

PHYSICAL ACTIVITY LEVEL:

<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Moderately Active	<input type="checkbox"/> Moderately Restricted
<input type="checkbox"/> Active	<input type="checkbox"/> Sedentary	<input type="checkbox"/> Marked Restricted

Have you ever taken steroids before (Prednisone)? No Yes. If yes, please indicate how long ago:
 1-7 days ago 2-4 weeks ago 2-6 months ago 7-12 months ago 1 or more years

Have you taken steroids during the past month? No Yes. What is the dose (mg/frequency) .

Please answer the following questions. If you do not know the answer, write **“DK”** (don't know).

1. What was the highest dose of steroids you have ever taken? _____
2. How long did you take this dose? _____
3. Why were you prescribed steroids? *(Check the appropriate answers below)*

<input type="checkbox"/> Nephrotic Syndrome	<input type="checkbox"/> Brain or Spine Surgery
<input type="checkbox"/> Kidney Transplantation	<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> Other Kidney Disorder	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Other Organ Transplantations	<input type="checkbox"/> Systemic Lupus Erythematosus
<input type="checkbox"/> Skin Disorder	<input type="checkbox"/> Allergy
<input type="checkbox"/> Collagen Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Herb Medication	<input type="checkbox"/> Other: _____

Completed by: _____ Date _____
Patient/Guardian

This questionnaire has been reviewed with the patient.

Physician/Resident/PA or Nurse's Signature Date _____

**Johns Hopkins Orthopaedics
at Good Samaritan Hospital**
5601 Loch Raven Boulevard
Smyth Building, Suite G-1
Baltimore, MD 21239
443-444-4730/Fax 443-444-4752
jhortho@jhmi.edu
www.hopkinsorthogsh.com



Referral Policy

Dear Patient;

If your health insurance plan is one which requires that you obtain a referral in order for you to see a specialist healthcare provider, please be sure to bring it with you for your scheduled visit with us. You may also have your Primary Care Physician fax it directly to our office using the above fax number.

In today's healthcare environment, the need to obtain a referral can be very confusing and frustrating. Please contact your Primary Care Physician before your appointment with us so you can determine with certainty whether or not you will need to obtain a referral.

If we have not received the necessary referrals by the time of your visit, then it will be necessary to:

1. Reschedule your appointment for a later date or
2. Pay for your visit and submit the insurance paperwork yourself.

Rescheduling appointments is disruptive for everyone and we would prefer not to take that action.

We thank you very much for your cooperation in this matter. Please let us know if you have any questions.

Sincerely,

Johns Hopkins Orthopaedic and Spine Surgery
at Good Samaritan Hospital

**Johns Hopkins Orthopaedics
at Good Samaritan Hospital**
5601 Loch Raven Boulevard
Smyth Building, Suite G-1
Baltimore, MD 21239
443-444-4730/Fax 443-444-4752
jhortho@jhmi.edu
www.hopkinsorthogsh.com



Dear Patients and Family Members:

Effective January 1, 2009 the Department of Orthopaedic Surgery at Johns Hopkins instituted a policy, charging a fee of \$25.00 per form/letter that is to be completed by the patient's surgeon. This fee would apply to following:

Disability Forms

FMLA Forms

Home and Hospital Teaching Forms

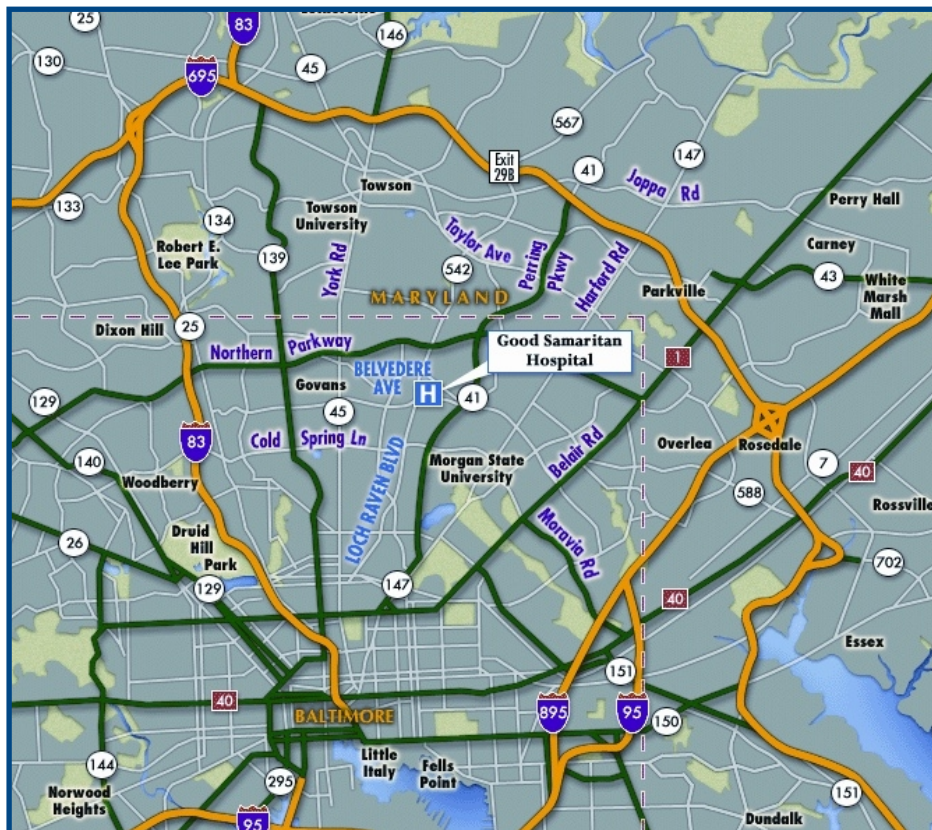
Special Request Letters

The advance fee of \$25.00, payable in cash, check or money order, is required to process any of the forms. Checks should be made payable to the Department of Orthopaedic Surgery and mailed directly to our office. All forms will be completed within 10 days of receiving payment. As a courtesy to our surgical patients, one form will be completed at no charge, per surgery (this does not apply to FMLA or Disability forms). All disability forms subsequent to the initial Disability form will be completed at no charge.

If you have an questions, please do not hesitate to contact us.

Thank You,

Johns Hopkins Orthopaedic and Spine Surgery



Directions to Good Samaritan Hospital

From the NORTHEAST:

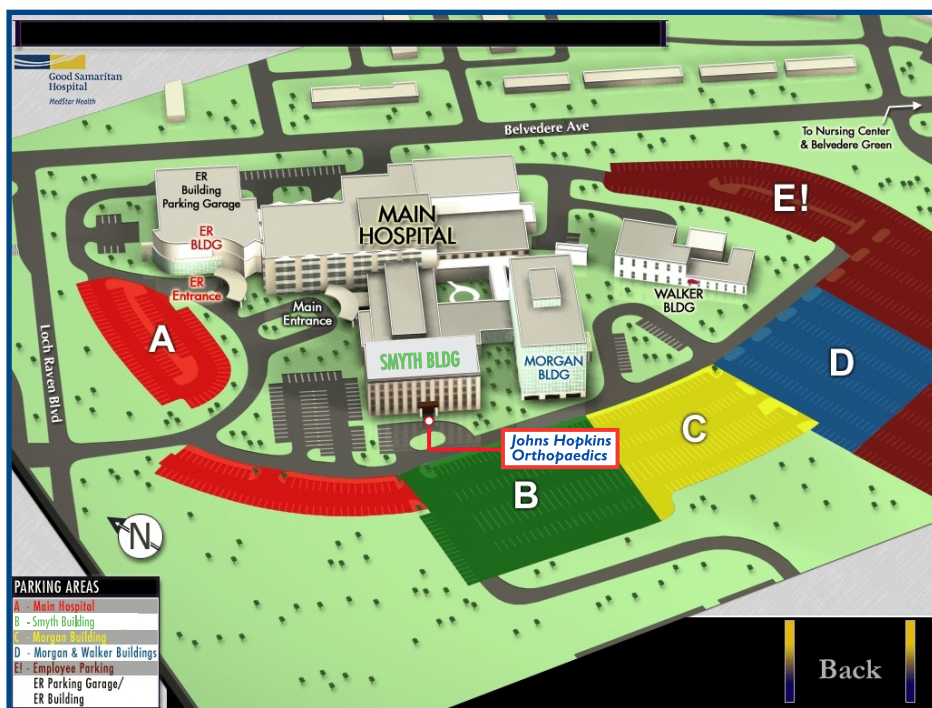
Take I-695 to Loch Raven Boulevard, South. Alternately, take either Harford Road, Perring Parkway, or Belair Road South, make a right onto Northern Parkway and then a left onto Loch Raven Boulevard. Cross over Belvedere Avenue and take a left into the Hospital driveway.

From the NORTHWEST:

Take I-695 to I-83 South. Exit onto Northern Parkway, East. Turn right at Loch Raven Boulevard Exit 29B. Cross over Belvedere Avenue and take a left into the Hospital driveway.

From the SOUTH:

Take I-95 North through the Fort McHenry Tunnel to Exit 60, Moravia Road. Moravia turns into Cold Spring Lane after Harford Road. Proceed on Cold Spring and go right onto Loch Raven Boulevard. Cross over to Woodbourne Avenue and take a right into the Hospital driveway.



Location:

Our main office is located in Suite G-1.

- Proceed through the front door of the Smyth Building.
- We are the first door on the LEFT after the elevator
- Please note our directory and The Johns Hopkins sign on the right side of the door.

Suite 204:

- Proceed through the front door of the Smyth Building.
- Take the elevator on your LEFT to the 2nd floor.
- Make a RIGHT out of the Elevator.
- Follow Signs to Suite 204