CEDARS-SINAI®

ORTHOPAEDIC CENTER

Dr. Sean Rajaee

# NEW PATIENT INFORMATION

PATIENT I.D.

Last Name: _____ First Name: _____ MI: _____

Age: _____ Date of Birth: _____ Occupation: _____ ☐ Not Working

Exercises: ☐ Light ☐ Medium ☐ Heavy

Family History of: Cancer ☐ No ☐ Yes Diabetes ☐ No ☐ Yes Bleeding ☐ No ☐ Yes

**Social History**

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you live alone: ☐ Yes ☐ No

How many children do you have: _____ ☐ None

Will you have a caregiver to assist you if surgery is needed? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No

Have you lost work due to your foot or ankle problem? ☐ Yes ☐ No

Do you have stairs in your home? ☐ Yes ☐ No

Do you think you are at risk for a fall? ☐ Yes ☐ No

Date symptoms began: _____

**Current Problems**

Chief complaint or reason for visit: _____

_____

_____

Cause of present problem *(e.g. work related injury, auto accident, slip-and-fall, etc.):*

_____

What favorite activities does your pain prevent?: _____

_____

Can you care for yourself? *(e.g. dressing, eating, toileting, standing up, etc.):*

_____

Other difficult functions include: _____

Please mark No or Yes for each complaint. Explain "yes" answers on back of sheet.

| | No | Yes | | No | Yes | | No | Yes |
|---|---|---|---|---|---|---|---|---|
| Weight change | ☐ | ☐ | Thyroid problems | ☐ | ☐ | Dizziness | ☐ | ☐ |
| Bleeding | ☐ | ☐ | Diabetes | ☐ | ☐ | Stroke | ☐ | ☐ |
| Blood clots | ☐ | ☐ | Blood transfusion | ☐ | ☐ | Seizures | ☐ | ☐ |
| Heart problems | ☐ | ☐ | Difficult walking | ☐ | ☐ | Epilepsy | ☐ | ☐ |
| Blood pressure | ☐ | ☐ | Swollen legs | ☐ | ☐ | Cancer | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | Joint pain | ☐ | ☐ | Easy bruising | ☐ | ☐ |
| Hearing | ☐ | ☐ | Arthritis | ☐ | ☐ | Skin problem | ☐ | ☐ |
| Eye problems | ☐ | ☐ | Bone disease | ☐ | ☐ | Mental illness | ☐ | ☐ |
| Nosebleeds | ☐ | ☐ | Back problems | ☐ | ☐ | Are you pregnant? | ☐ | ☐ |
| Difficulty swallowing | ☐ | ☐ | Gout | ☐ | ☐ | | | |

Are you experiencing pain now? ☐ Yes ☐ No

If yes, where is the location of your pain? _____

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How much pain do you feel now? 0 1 2 3 4 5 6 7 8 9 10

*(On scale of 0-10, with 10 being the most painful, please circle what you are feeling right now)*

How much pain can you tolerate? 0 1 2 3 4 5 6 7 8 9 10

*(On scale of 0-10, with 10 being the most painful, please circle what you can tolerate)*

Does this pain prevent you from: Working? Walking? Doing daily activities? Sports?

If so, what activity? _____

Have you taken any pain medications within the last 24 hours? ☐ No ☐ Yes

If you have taken medication for pain, what did you take? _____ How much? _____

**Past History**

Past or ongoing medical problems *(e.g. high blood pressure, stroke, diabetes, heart conditions, cancer, etc.):* _____

**Previous Surgeries**

| Name of operation: | Date: |
|---|---|
| | |
| | |
| | |

**Other Information**

Do you smoke? ☐ No ☐ Yes Number of cigarettes per day _____

Do you drink alcohol? ☐ No ☐ Yes Number of drinks per day _____

Have you had imaging in the last 3 months?

☐ No ☐ Yes ☐ MRI ☐ CT scan ☐ X-rays

**Allergies**

Please list all allergies and response such as rash, itching, difficulty breathing, or unknown:

| **Drug Name:** | **Reaction:** |
|---|---|
| | |
| | |
| | |

**Medications**

Please list all current medications, over the counter drugs, vitamins and herbals.

Please give us the total number of "as needed" medication taken in a 24-hour period.

| **Name** | **Dosage** | **Time of Day** | **Total taken in 24 hours** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| Patient / Guarantor Printed Name | Patient / Guarantor Signature | Date | Time |
|---|---|---|---|
| | | | |
| CSMC Representative Printed Name | CSMC Representative Signature | Date | Time |
| | | | |

**Sean S. Rajaee, M.D., M.S.**
**Adult Reconstruction and Joint Replacement Surgeon**
**Cedars-Sinai Medical Center**

Patient Name: _____

Nursing Clinic Questionnaire:

Referring Physician: _____

What joint hurts? _____Right Hip _____ Left Hip _____Right Knee _____Left Knee

How long have you been dealing with this symptom?

_____ Days. _____ Weeks. _____ Months. _____ Years

Have you had any treatment specifically for this symptom before?

**Medications:** Have you tried medications such as Advil/Aleve/Tylenol?

**Which one? _____**

**Is it helpful?_____**

**Any Injections?** _____(Y/N). What Type? _____

If yes, was it helpful: _____(Y/N) # of Injections:_____

Date of most recent injection: _____

**Any Physical Therapy?** _____(Y/N, and approximate date)

**Any surgery on this specific joint?**
If yes, please list dates and surgery information:

_____
**Other Treatment: (Acupuncture, chiropractor, etc):**

_____

What treatment do you think you want or need at this time?

_____