Keck Medicine of USC

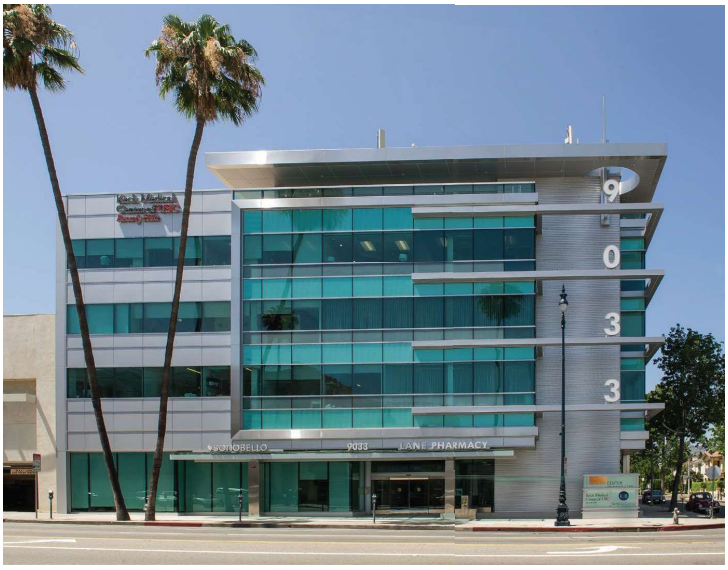
Orthopaedic Surgery
9033 Wilshire Blvd, Suite 360
Beverly Hills, CA 90211
Office: (310) 281-5010 | **Fax:** (310) 281-5011
web: keckmedicine.org/services/orthopedics
web: totaljoints.net

Dear Patient:

Welcome to Keck Medicine of USC - Beverly Hills, Orthopaedic Surgery. We thank you for choosing USC, a trusted leader in quality health care.

Please prepare for your appointment with the following:

- Submit completed intake forms 2 business days prior to your appointment.
- Bring applicable insurance card(s).
- Bring valid government issued picture identification.
- Bring images from an outside facility (if applicable).
- Wear comfortable and loose clothing.
- Underground parking is available for all patients and visitors. The entrance is off Wetherly Street, on the right side of the building. The fee is $2.50 every 15 minutes with a maximum of $22.50 per day. Only credit cards are accepted. Unfortunately, we do not validate at this time.



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Please complete the following questionnaire.

Your Care Team

Referring Provider

Name:

Address: City:

State: Zip Code:

Phone Number: Fax Number:

Primary Care Provider

Name:

Address: City:

State: Zip Code:

Phone Number: Fax Number:

Cardiology Provider (if applicable)

Name:

Address: City:

State: Zip Code:

Phone Number: Fax Number:

Pharmacy

Name of Preferred Pharmacy

Address: City:

State: Zip Code:

Phone Number: Fax Number:

PATIENT ID

Name: _____

DOB: _____

Current Medications

Please include prescription, over the counter, samples, vitamins, herbal products, respiratory treatments, parenteral nutrition, supplements, and any other FDA substance listed as a drug.

Name of Medication	Dose	Frequency

Allergies	
Type	**Name and Reaction (rash, difficulty breathing, GI Upset)**
Medication	
Latex	
Other	

Health History Questionnaire

Height:_____ **Weight:** _____

Where is your pain located? _____

Which side of your body? _____

How long have you had the pain? _____

How far can you walk comfortably? _____

Please circle your pain using the scale below, where 0 is "No Pain" and 10 is "Worst Pain".

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

Other Symptoms: (Check all that apply)

☐ Limping	☐ Fatigue	☐ Grinding	☐ Swelling
☐ Weakness	☐ Falling	☐ Stiffness	☐ Clicking
☐ Locking	☐ Pain at night	☐ Buckling	☐ Low back Pain
☐ Leg Length Discrepancy	☐ Instability	☐ Guarding	☐ Other:

Are your symptoms worsened by: (Check all that apply)

☐ Walking	☐ Standing	☐ Stairs	☐ Hills
☐ Uneven ground	☐ Getting Dressed	☐ Work	☐ Exercise
☐ Sports	☐ Travel	☐ Cold Weather	☐ Twisting
☐ Pivoting	☐ Bending	☐ Getting into/out of a car	☐ Putting on shoes
☐ Crossing legs	☐ Sitting	☐ Other:	

How have you tried to manage your symptoms: (Check all that apply)

☐ NSAIDs	☐ Narcotics	☐ Physical Therapy	☐ Arthroscopy
☐ Tylenol	☐ Trainer	☐ Shoe Lift	☐ Time off Work
☐ Ice	☐ Weight Loss	☐ Glucosamine	☐ Chiropractor
☐ Acupuncture	☐ Topical Rubs	☐ CBD/THC	

Have you tried injection therapy: (Check all that apply)

☐ Steroids	☐ Viscosupplementation (Knee gel shots)	☐ PRP	☐ Stem Cell

Do you use assistive devices: (Check all that apply)

☐ Walker	☐ Wheelchair	☐ Brace	☐ Cane
☐ Crutches	☐ Other:		

Medical History

Do you have, or have you ever been treated for any of the following?
Please answer this section carefully and completely as this information will determine your surgical care plan. **(We know that this is a long list, but this information is important)**

General Information

- ☐ Cancer: Type:_____Ongoing Treatment? ☐ Yes ☐ No
- ☐ Blood Thinner: Which One: _____
- ☐ Blood Clot (DVT or PE): Where:_____
- ☐ AICD/Pacemaker: Manufacturer: _____
- ☐ Spinal Stimulator: Manufacturer: _____
- ☐ Live Alone
- ☐ Stairs at Home
- ☐ Are you in pain management?
- ☐ Are you on any weight-loss medications?

Cardiopulmonary

- ☐ Arrhythmia/Palpitations
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ COPD
- ☐ Cardiac Stents
- ☐ Heart Surgery
- ☐ Aortic Stenosis
- ☐ Sleep Apnea
- ☐ Valve Replacement

Neurological

- ☐ Stroke
- ☐ Seizures
- ☐ Parkinson's Disease
- ☐ Alzheimer's
- ☐ Other Dementia
- ☐ Glaucoma
- ☐ Loss of Hearing
- ☐ Migraine Headaches
- ☐ Vertigo
- ☐ Balance Problems
- ☐ Depression
- ☐ Anxiety
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Fainting

Gastrointestinal

- ☐ Diabetes
- ☐ Prediabetes
- ☐ GI Bleed or Ulcers
- ☐ Constipation
- ☐ Colitis
- ☐ Gastric Bypass/Sleeve
- ☐ GERD
- ☐ Motion Sickness
- ☐ Difficulty swallowing
- ☐ Cirrhosis of liver
- ☐ Crohn's disease
- ☐ Nausea (esp post-op)

Genitourinary

- ☐ Urinary Incontinence
- ☐ BPH (Enlarged Prostate)
- ☐ Kidney Disease

Hematology

- ☐ Anemia
- ☐ Blood clotting disorder:
- ☐ Bleeding disorder:
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Von Willebrand's
- ☐ Frequent Nose Bleeds

Musculoskeletal

- ☐ Osteopenia
- ☐ Arthritis in other joints
- ☐ Scoliosis
- ☐ Rheumatoid Arthritis
- ☐ Ehlers's Danlos
- ☐ Autoimmune disease

Infectious Diseases

- ☐ HIV
- ☐ Hepatitis; type:_____
- ☐ History of Staph Infection
- ☐ History of *C. Diff*

Orthopaedic History

Please include ***any musculoskeletal or joint-related*** surgeries or ***history of fractures***.

Procedure	Date	Surgeon

Surgical History

Please include any ***additional*** surgeries.

Procedure	Date	Surgeon

PATIENT ID

Name: _____

DOB: _____

Advance Directive

Do you have an Advanced Directive? YES ☐ NO ☐

Falls Screening

In the past 6 months…

have you worried about falling or felt unsteady? YES ☐ NO ☐

have you had any near falls or falls? YES ☐ NO ☐

have you had a fall related injury with symptoms lasting longer than 5 days? YES ☐ NO ☐

External Facility Imaging Information

Please complete this information if you're bringing in external x-rays or MRIs to your visit.
X-Rays must be taken within the past 6 months to be evaluated. **CD Only, Report not needed.**
MRIs must be taken within a year. **CD and Report needed.**
If you are unable to bring images, please expect to take x-rays here in office.

X-RAY

Body Part: _____

Date Taken: _____

Name of Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

MRI

Body Part: _____

Date Taken: _____

Name of Facility: _____

Address: _____

Phone Number: _____ Fax Number: _____

PATIENT ID

Name: _____

DOB: _____