Stony Brook Medicine

PATIENT HISTORY – PRIOR JOINT REPLACEMENT

NAME _____ **TODAY'S DATE** _____

I AM HERE FOR ISSUES WITH MY PRIOR REPLACEMENT SURGERY (PLEASE CHECK BOXES THAT APPLY)

HIP ☐ **KNEE** ☐ **BOTH** ☐ **LEFT** ☐ **RIGHT** ☐

JOINT REPLACEMENT SURGERY HISTORY
(Please fill out in order from the first joint replacement surgery on the joint we will look at today to the last surgery you have had on that hip or knee)

Month/Year of Surgery	**Type of Surgery**	**Surgeon**	**Hospital**	**Do you have the operative report?**	**Issues during or after the surgery** (Infection/Dislocation/Fracture/ Blood clots etc.)
				☐ Y ☐ N	
				☐ Y ☐ N	
				☐ Y ☐ N	
				☐ Y ☐ N	

HAS FLUID BEEN TAKEN FROM THE JOINT AFTER THE JOINT REPLACEMENT SURGERY? ☐ Y ☐ N

IF YES, HOW MANY TIMES, WHEN, AND BY WHOM? _____

WHAT WERE THE RESULTS OF TESTS ON THAT FLUID? _____

HAS IMAGING OTHER THAN PLAIN X-RAYS BEEN DONE OF THE JOINT AFTER YOUR LAST JOINT REPLACEMENT SURGERY

(MRI/ULTRASOUND/BONE SCAN)? ☐ Y ☐ N

ARE THESE STUDIES AVAILABLE AND WHAT DID THEY SHOW? _____

DO YOU HAVE PAIN? ☐ Y ☐ N DO YOU HAVE INSTABILITY? ☐ Y ☐ N

WHEN DID THESE SYMPTOMS FIRST START? _____

HAVE YOU HAD: FEVERS ☐ Y ☐ N DRAINAGE ☐ Y ☐ N REDNESS ☐ Y ☐ N

NUMBNESS/TINGLING IN THAT LIMB ☐ Y ☐ N WEAKNESS IN THAT LIMB ☐ Y ☐ N

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