



Oklahoma Joint Reconstruction Institute

Paul B. Jacob, DO

Dear Patient,

I would like to be the first to welcome you to *Oklahoma Joint Reconstruction Institute*. We know you have many choices when it comes to your orthopedic needs and we thank you for trusting us with your care. We also want to thank you for taking your valuable time to fill out this packet of information as it will help us to better understand your condition.

Your first appointment will take approximately 30-45 minutes, and I will do my best to run as close as possible to your allotted appointment time. I do take care of urgent / emergent patients and I ask for your understanding and patience as from time to time your appointment may get rescheduled or I may be running late. I agree to extend the same courtesy to my patients' as I understand that unforeseen events may delay your arrival. I will do my best to accommodate late patients as my schedule permits. The attached packet will give you some important details on my practice. Please don't hesitate to contact me personally at drjacob@drpauljacob.com or my scheduler at (405) 424-5426 with questions at any time during your care.

I am a Board Certified and Fellowship Trained Orthopedic Surgeon specializing in advance hip and knee replacement and adult reconstruction. I was fortunate to have to opportunity to complete my training at the world-renowned Cleveland Clinic in Cleveland, Ohio. My experience working with some of the world's leading experts in the field of adult reconstruction has allowed me to bring the most advanced techniques in minimally invasive surgery to the state of Oklahoma. This includes robotically assisted and minimally invasive hip and knee replacement utilizing the latest in rapid recovery protocols. My practice is solely focused on adult reconstruction of the lower extremity. I am committed to providing the most advanced techniques available for the residents of the state of Oklahoma and surrounding states. I am passionate about achieving excellent results for my patients. A caring, professional approach to patient care combined with advanced surgical techniques is paramount. I also believe that monitoring of surgical results is critical. I am proud to say that our practice actively participates in the American Joint Replacement Registry.

WHAT TO BRING TO YOUR APPOINTMENT

- Driver's License or a valid ID
- Insurance information (card)
- Medical records from previous orthopedic surgeons
- Disc of previous imaging (X-rays, MRIs, CT scans etc.)
- List of medications (if any)
- Hospital medical records from previous surgeries

We realize that you will receive a great deal of information regarding your diagnosis and its associated treatment in a very short period of time. The amount and pace of information can be overwhelming. My website www.drpauljacob.com contains further information about my practice, research and experience. It also contains useful educational material on your diagnosis, surgical procedure and rehabilitation. If you are not provided with all the answers to your questions from these resources, please do not hesitate to contact us at any time for further assistance.

The prospect of undergoing a major surgery can sometimes be a stressful on you and your loved ones. We have designed a full program to inform you of your options, educate you on the process and minimize any stress / inconvenience that you may experience.

No matter your level of activity; whether you want to return to high level sport or be free of pain and enjoy everyday life, I am dedicated to helping you achieve your goals and live life to the fullest. I hope to be of assistance and look forward to meeting you soon.

Sincerely,

Paul B. Jacob D.O.
Oklahoma Joint Reconstruction Institute
Board Certified and Fellowship Trained Orthopedic Surgeon
Specializing in Advanced Reconstruction of the Hip and Knee
Email: drjacob@drpauljacob.com
Office: (405) 424-5426
Fax: (405) 424-5431
Website: www.drpauljacob.com

General Patient Information

Name: _____ Age: _____ Date Of Birth: _____ Height: _____ Weight: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Preferred contact method: Home Phone Cell Phone Email Other: _____

Emergency Contact Name: _____ Phone #: _____

Pharmacy Name: _____ Phone#: _____

Reason for the Visit?

- Hip Pain Left Right Bilateral
- Knee Pain Left Right Bilateral
- This is a second opinion
- I have a problem with my existing hip / knee replacement
- Other: _____
- When did symptoms begin? _____

Please let us know if you see any of the following physicians:

Primary care physician: _____ Cardiologist (heart doctor): _____

Rheumatologist (arthritis doctor): _____ Pulmonologist (lung doctor): _____

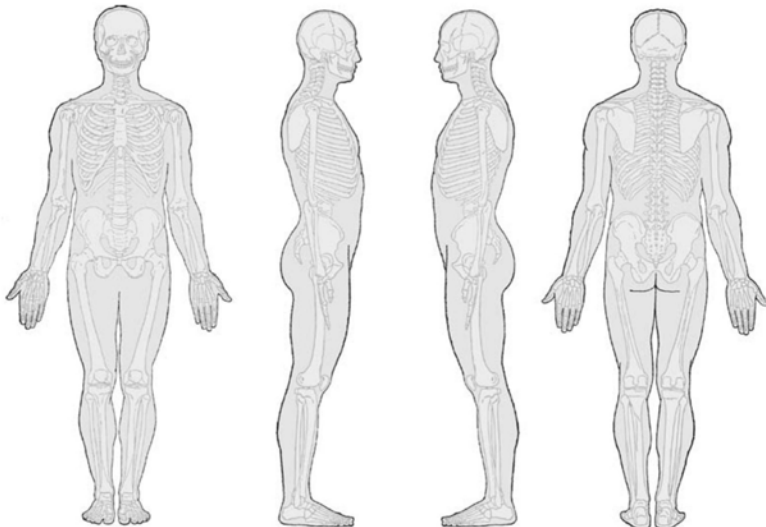
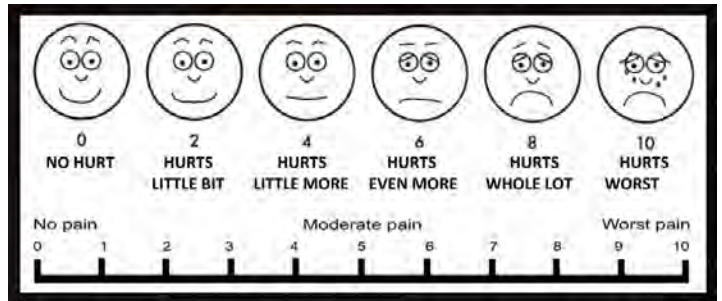
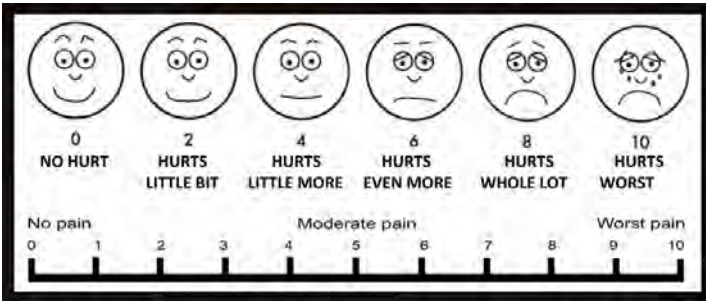
Pain Management: _____ Nephrologist (kidney doctor): _____

Other: _____

In your words please describe why you are seeing Dr. Jacob: _____

Circle the number below that best corresponds to your pain at its **BEST**

Circle the number below that best corresponds to your pain at its **WORST**



Mark with an "X" where you are experiencing your pain

Please check all the boxes that describe your symptoms:

- Aching
- Throbbing
- Burning
- Numbness
- Tingling
- Heaviness
- Locking
- Grinding
- Stiffness
- Sharp
- Stabbing
- Electric shock
- Ants crawling
- Pins / Needles

Past Treatments

Insurances often will not approve major surgeries like hip or knee replacements until the patient has made attempts at conservative treatment for a minimum of 3 months. Please indicate all conservative treatments you have attempted below:

I CAN NOT TAKE ANTI-INFLAMMATORY MEDICATIONS (REASON): _____

WEIGHT LOSS	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
ACTIVITY MODICATION	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
OVER THE COUNTER MEDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
PRESCRIPTION NSAID'S	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
PRESCRIPTION PAIN MEDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
TOPICAL MEDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
ALTERNATIVE MEDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
PHYSICAL THERAPY	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
AQUATIC THERAPY	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
CHIROPRACTIC	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
ACUPUNCTURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
HOME EXERCISE	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
STEROID INJECTION: # _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
GEL INJECTIONS: # _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
STEM CELL INJ. # _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
PRP INJECTIONS # _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
BRACING	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
WALKER / CANE / CRUTCH	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
REST / ICE / ELEVATION	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
NERVE BLOCKS	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
ARTHROSCOPIC SURGERY	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
OSTEOTOMIES	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
CARTILAGE TRANSPLANT	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
MICROFRACTURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks
ORTHOTICS / TAPING	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have tried this treatment over the following timeframe	<input type="checkbox"/> Less than 12 weeks	<input type="checkbox"/> Greater than 12 weeks

Please describe any other treatments that you have attempted that are not listed above: _____

Review of Systems

Please check the box next to any of the symptoms you are experiencing currently.'

- I DO NOT HAVE ANY OF THE FOLLOWING SYMPTOMS
 I am currently pregnant

General:

- Chills
- Excessive Weight Gain
- Excessive Weight Loss
- Fatigue
- Fever
- Night Sweats
- Difficulty Sleeping

Cardiovascular:

- Chest Pain
- Shortness of Breath
- Palpitations
- Irregular Heartbeat
- Leg Swelling
- Pitting Edema
- Heart Murmur
- Fainting

Skin:

- Discoloration
- Easy Bruising
- Hives
- Rashes
- Open wounds
- Reaction to Metal
- Trouble Healing Wounds
- Have a wound care doctor

Gastrourinary:

- Urinary Frequency
- Urinary Retention
- Bowel Incontinence
- Bladder Incontinence
- Constipation

Hematology:

- Excessive Bruising
- Excessive Bleeding
- Blood Transfusions
- Anemia

Gastrointestinal:

- Nausea
- Vomiting
- Constipation
- Loose stool
- Poor Appetite
- Poor Nutrition

Eyes / Ears / Nose / Throat:

- Vertigo / dizziness
- Hearing Loss
- Nose Bleeds
- Visual Changes
- Ringing in Ears

Endocrine:

- Excessive Thirst
- Heat Intolerance
- Cold Intolerance

Respiratory:

- Cough
- Wheezing
- Coughing Blood
- Require oxygen at home
- History of pneumonia
- Sleep apnea
- Use a CPAP

Shortness of breath when:

- Walking 2 blocks
- 1 flight of steps
- When I lay down

Psychiatric:

- Anxiety / Worrying
- Depression
- Excessive Crying
- Trouble Focusing
- Memory Loss
- Mood Swings
- Excessive Fear

Neurologic:

- Weakness
- Tremors
- Numbness
- Tingling
- Burning Sensation
- Seizures
- Memory Loss
- Headaches
- Paralysis
- Foot Drop
- Loss of Consciousness
- Headaches
- Slurred Speech

Musculoskeletal:

- Pain Going Up Stairs
- Pain Going Downstairs
- Back Pain
- Neck Pain
- Hip Pain
- Knee Pain
- Muscle Atrophy
- Limping
- Joint Stiffness
- Leg Length Difference
- Use of Walker / Cane
- Trouble Getting Dressed
- Locking of Joints
- Popping of Joints
- Feeling of Instability
- Joint Swelling
- Muscle Cramps

Allergic / Immunologic:

- Hives
- Persistent Infections
- HIV Exposure
- Hepatitis Exposure
- Rash from Jewelry
- Rash from Meta

Past Medical History

- I don't have any past medical history

- Depression
- Anxiety
- Cancer
- Asthma
- COPD
- Emphysema
- Diabetes Type I
- Diabetes Type II
- Heart Burn / Reflux
- Heart Attack
- High Cholesterol
- High Blood Pressure
- Stroke
- Gout
- Osteoporosis
- Thyroid Disease
- HIV

- Hepatitis A
- Hepatitis B
- Hepatitis C
- Hepatitis (other)
- Hiatal Hernia
- Kidney Failure
- Kidney Stones
- Liver Disease
- Rheumatoid Arthritis
- Osteoarthritis
- Psoriatic Arthritis
- Autoimmune Arthritis
- Fibromyalgia
- Alcohol Abuse/Addiction
- History of MRSA
- Anemia
- Deep Vein Thrombosis

- Pulmonary Embolism
- Bleeding Disorder
- Factor V Leiden
- Factor Deficiency
- Phlebitis
- History of Seizures
- Thyroid Disease
- Tuberculosis
- Pneumonia
- Obstructive Sleep Apnea
- MRSA Infection
- Gastric Ulcers
- GI Bleeding
- Crohn's disease
- Ulcerative colitis
- Irritable bowel syndrome

Family History

I don't know my family history

- Heart Attack
- Stroke
- TIA (Mini Stroke)
- Cancer
- Breathing Problems
- Diabetes

- High Blood Pressure
- Arthritis
- Bleeding Problems
- Blood Clots
- Phlebitis
- Pulmonary Embolism

- Liver Disease
- Arthritis
- Osteoporosis
- Rheumatoid Arthritis
- Thyroid Disease
- Autoimmune Disease

Please use the space below to provide any information you feel we should know about your past or current medical history: _____

Past Surgical History

Please list all of the SURGERIES you have had

<i>Surgery</i>	<i>Hospital</i>	<i>Physician</i>	<i>Complications?</i>	<i>Year</i>
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

Please use the space below to provide any information you feel we should know about your past surgical history: _____

Have you been hospitalized in the past 5 years? YES NO

If yes please describe: _____

Social History

Tobacco Use:

- I Have Never Been a Smoker
- I Quit Smoking _____(Days / Months / Years) Ago
- I Smoked for _____ Years
- I Am a Current Cigarette Smoker
- I Have Smoked for _____ Years
- I Smoke _____ Packs Per Day
- I Use Smokeless Tobacco
- I Use Other Tobacco Products: _____
- I am interested in quitting

Alcohol Use:

- I Drink Alcohol Daily
- I Drink Socially
- I Don't Consume Alcohol

Drug Use:

- I Do Not Use Illegal Drugs
- I Use Recreational Drugs: _____

Exercise:

- I Do Not Exercise
- I Exercise Weekly
- Type of Exercise: _____

Occupation:

- I Am Currently Working as a(n): _____
- This was a workplace Injury
- Employer: _____
- I Am Currently Unemployed
- I am Retired from: _____

Lives with (check all that apply):

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Children | | <ul style="list-style-type: none"> <input type="checkbox"/> Parent(s) <input type="checkbox"/> Grandparents <input type="checkbox"/> Friend / Roommates |
|--|--|--|

Do you have any stairs that you will need to navigate at home? YES NO If yes, how many stairs are there in the home: _____

Have you had one of the following heart tests:

(place a ✓)	I have had the following	Year	Location of testing
<input type="checkbox"/> Yes <input type="checkbox"/> No	EKG		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stress Test		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Echocardiogram (ultrasound of heart)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stent Placement?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac surgery, please specify:		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other cardiac procedure:		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker/AICD		

if you marked yes to having a Pacemaker or AICD please provide the following info

Date pacemaker was last checked: _____ Model number or type of pacemaker: _____

This model is MRI safe: Yes No I am not sure

I have my pacemaker card and can provide a copy

Please use the space below to provide any information you feel we should know about your cardiac history: _____

CURRENT MEDICATIONS

I am on the following **PAIN MEDICATIONS**

I am not currently taking any opioid based (narcotic) pain medications

1. Drug Name: _____ Dose: _____ How Often: _____
2. Drug Name: _____ Dose: _____ How Often: _____

Daily Medications (Please include over the counter medication and food supplements).

- Drug Name: _____ Dose: _____ How Often: _____
- Drug Name: _____ Dose: _____ How Often: _____
- Drug Name: _____ Dose: _____ How Often: _____
- Drug Name: _____ Dose: _____ How Often: _____
- Drug Name: _____ Dose: _____ How Often: _____
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- Drug Name: _____ Dose: _____ How Often: _____
- Drug Name: _____ Dose: _____ How Often: _____

Are you on any Rheumatoid Arthritis or autoimmune disease medications? YES NO

- | | | |
|--|---|--|
| <input type="checkbox"/> Methotrexate
<input type="checkbox"/> Sulfasalazine
<input type="checkbox"/> Hydroxychloroquine (Plaquenil)
<input type="checkbox"/> Leflunomide (Arava)
<input type="checkbox"/> Adalimumab (Humira)
<input type="checkbox"/> Etanercept (Enbrel)
<input type="checkbox"/> Golimumab (Symponi) | <input type="checkbox"/> Infliximab (Remicade)
<input type="checkbox"/> Abatacept (Orencia)
<input type="checkbox"/> Certolizumab (Cimzia)
<input type="checkbox"/> Rituximab (Rituxan)
<input type="checkbox"/> Tocilizumab (Actemra)
<input type="checkbox"/> Anakina (Kineret)
<input type="checkbox"/> Secukinumab (Cosentyx) | <input type="checkbox"/> Ustekinumab (Stelara)
<input type="checkbox"/> Belimumab (Benlysta)
<input type="checkbox"/> Tofacitinib (Xeljanz)
<input type="checkbox"/> Mycophenolate Mofetil
<input type="checkbox"/> Azathioprine
<input type="checkbox"/> Cyclosporine
<input type="checkbox"/> Tacrolimus |
|--|---|--|

OTHER: _____

Allergies

(please describe the reaction on the line provided)

- NO KNOWN DRUG ALLERGIES
- I Have an allergy to **LATEX**
- I Have an allergy to **TOPICAL IODINE (BETADINE)**
- I Have an allergy to **IV IODINE**

<u>Drug Allergy</u>	<u>Reaction</u>

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

ARE YOU CURRENTLY TAKING ANY <i>HORMONES?</i> (<u>ANYTHING</u> CONTAINING ESTROGEN OR TESTOSTERONE)	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER HAD A BLOOD CLOT ALSO CALLED A DEEP VEIN THROMBOSIS (DVT) IN YOUR LEGS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER HAD A BLOOD CLOT IN YOUR LUNGS OR A PULMONARY EMBOLISM (PE) IN YOUR LUNGS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER HAD PHLEBITIS (SUPERFICIAL BLOOD CLOT)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAS AN IMMEDIATE FAMILY MEMBER EVER HAD A DVT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAS AN IMMEDIATE FAMILY MEMBER EVER HAD A PE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAS AN IMMEDIATE FAMILY MEMBER EVER HAD A PHLEBITIS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
ARE YOU CURRENTLY ON A PRESCRIBED BLOOD THINNER THAT YOU ARE AWARE OF?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE ANY CARDIAC STENTS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU BEEN DIAGNOSED WITH KIDNEY FAILURE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU BEEN DIAGNOSED WITH BLEEDING ULCERS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE TROUBLE TOLERATING OR HAVE YOU BEEN TOLD NOT TO TAKE ASPIRIN?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE A HISTORY OF SEIZURE DISORDERS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU BEEN DIAGNOSED WITH DEPRESSION?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU BEEN DIAGNOSED WITH AN ANXIETY DISORDER?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU BEEN DIAGNOSED WITH LIVER FAILURE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU BEEN DIAGNOSED WITH HIV / AIDS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER BEEN DIAGNOSED WITH HEPATITIS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU BEEN DIAGNOSED WITH DIABETES?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU BEEN DIAGNOSED WITH HEART FAILURE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER HAD A TRANSIENT ISCHEMIC ATTACK (TIA)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER HAD A STROKE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE A HISTORY OF ANESTHESIA COMPLICATIONS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU WORK IN HEALTH CARE OR HAVE EXPOSURE TO MRSA?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE A HISTORY OF MRSA (STAPH) INFECTION?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE A HISTORY OF INFECTION AFTER SURGERY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU HAD TROUBLE HEALING AFTER PREVIOUS SURGERIES OR INJURIES?	<input type="checkbox"/> YES <input type="checkbox"/> NO
ARE YOU AN ORGAN TRANSPLANT RECIPIENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU HAD A PREVIOUS SURGERY ON THE OPERATIVE JOINT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU BEEN ON STEROIDS FOR A LONG TIME (PREDNISONE, CORTISONE.....)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU HAD A STEROID INJECTION ON THE OPERATIVE JOINT IN THE PAST 90 DAYS?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU USE TOBACCO PRODUCTS (ORAL TOBACCO, VAPING, CIGARS, CIGARETTES...)	<input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, ARE YOU WILLING TO QUIT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE AN ALLERGY TO TOPICAL IODINE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE AN ALLERGY TO LATEX?	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU HAD AN INFLUENZA VACCINE THIS YEAR? DATE: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU HAD A PNEUMONIA VACCINE THIS YEAR? DATE: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU BEEN DIAGNOSED WITH CANCER IN THE PAST 5 YEARS?	<input type="checkbox"/> YES <input type="checkbox"/> NO

If yes, please provide the following information:

Type of cancer: _____ Date of Diagnosis: _____

Did you require any of these treatment(s)?

Radiation Therapy Location: _____

Chemotherapy Type: _____

Lymph Node Removal Location: _____