



At Weir Orthopaedics, we focus on outpatient joint surgery. Here is a quick guide to see if outpatient joint surgery may be right for you.

<b>Age</b>	<input type="checkbox"/> Less than 82 years old	<input type="checkbox"/> 82 years old or older
<b>Body Type</b> (Choose one)	<input type="checkbox"/> 6'5" or taller and <b>less</b> than 345 pounds <input type="checkbox"/> 6'4"-6'2" and <b>less</b> than 330 pounds <input type="checkbox"/> 6'1"-5'11" and <b>less</b> than 305 pounds <input type="checkbox"/> 5'10"-5'8" and <b>less</b> than 277 pounds <input type="checkbox"/> 5'7"-5'5" and <b>less</b> than 255 pounds <input type="checkbox"/> 5'4"-5'2" and <b>less</b> than 232 pounds <input type="checkbox"/> Less than 5'2 and <b>less</b> than 225 pounds	<input type="checkbox"/> 6'5" or taller and <b>more</b> than 345 pounds <input type="checkbox"/> 6'4"-6'2" and <b>more</b> than 330 pounds <input type="checkbox"/> 6'1"-5'11" and <b>more</b> than 305 pounds <input type="checkbox"/> 5'10"-5'8" and <b>more</b> than 277 pounds <input type="checkbox"/> 5'7"-5'5" and <b>more</b> than 255 pounds <input type="checkbox"/> 5'4"-5'2" and <b>more</b> than 232 pounds <input type="checkbox"/> Less than 5'2 and <b>more</b> than 225 pounds
<b>Opioid Pain Medication</b>	<input type="checkbox"/> I do <b>not</b> take narcotic pain medication daily	<input type="checkbox"/> I take narcotic pain medication daily
<b>Support Person</b> (family, friends, neighbors)	<input type="checkbox"/> I have a reliable support person for 23 hours/day for 4 days after surgery <input type="checkbox"/> I have a reliable support person for 6 hours/day for 2 weeks after surgery	<input type="checkbox"/> I do <b>not</b> have a reliable support person for 23 hours/day for 4 days after surgery <input type="checkbox"/> I do <b>not</b> have a reliable support person for 6 hours/day for 2 weeks after surgery
<b>Outpatient Joint Surgery Candidate?</b>	<p>If most of your answers fall in this column, <b>you may be a good candidate</b> for outpatient joint surgery at Weir Orthopaedics. Please <b>fill out the remainder of this health form</b> starting on the back of this page.</p>	<p>If most of your answers fall in this column, <b>you may benefit from seeing a different surgeon</b> who focuses on inpatient joint surgery. We recommend speaking with your family doctor about surgeons who specialize in inpatient joint surgery</p>

**Patient Name:**

**Date of Birth:**

**Medical History:** Please mark if you have been diagnosed with the following

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Psoriasis                                    |
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Stroke        | <input type="checkbox"/> Gout   |
| <input type="checkbox"/> Blood clots         | <input type="checkbox"/> COPD          | <input type="checkbox"/> Rheumatoid Arthritis<br>requiring medication |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Cancer. Type: |   |

Other:		

**Surgical History:** Please mark if you have had any of the following

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Knee Scope (R/L) | <input type="checkbox"/> Hip Replacement (R/L) | <input type="checkbox"/> Knee Replacement (R/L) |
| <input type="checkbox"/> Spine Surgery    | <input type="checkbox"/> Heart Surgery         |   |

Other:		

**Medications:** Please list your current medications

- I do not take any medications


Your Pharmacy:

Location:

## Medical Allergies:

No Known Drug Allergies

Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:

## Family History: Please list any medical conditions that run in your family

No significant family history

Medical Condition:	Family Relation:
Medical Condition:	Family Relation:
Medical Condition:	Family Relation:
Medical Condition:	Family Relation:
Medical Condition:	Family Relation:

## Social History:

Use Tobacco:  Yes  No

Use Alcohol:  Yes  No

Use Illicit Drugs:  Yes  No

**Review Of Systems: Please mark if you have been diagnosed with the following**

**Constitutional**

- Weight Loss/Gain
- Weakness
- Fatigue
- Fever

**Eyes**

- Glasses/Contacts
- Blurred Vision
- Glaucoma
- Cataracts

**Ear Nose Mouth Throat**

- Ear Ringing
- Nasal Discharge
- Nosebleeds
- Bleeding Gums

**Gastrointestinal**

- Heart Burn
- Abdominal pain
- Gallbladder trouble
- Hepatitis

**Immunologic**

- Reaction to Drugs
- Skin Rashes
- Reactions to Foods

**Cardiovascular**

- High Blood Pressure
- Chest Pain
- Rheumatic Fever
- Palpitations

**Skin**

- Rashes
- Sores
- Lumps
- Dryness

**Neurological**

- Headache
- Dizziness
- Vertigo
- Seizures

**Genitourinary**

- Blood in Urine
- Urinary Infections
- Kidney Stones
- Burning Urination

**Psychological**

- Nervousness
- Depression
- Mood Changes

**Musculoskeletal**

- Muscular Weakness
- Stiffness
- Muscle Pain
- Joint Pain

**Blood or Lymph**

- Anemia
- Easy Bruising
- Easy Bleeding
- Swollen Glands

**Respiratory**

- Shortness of Breath
- Cough
- Wheezing
- Asthma

**Endocrine**

- Thyroid Trouble
- Excessive Sweating
- Excessive thirst