RISK ASSESSMENT: TOTAL JOINT REPLACEMENT AND SPINE FUSION

[Staff will complete the following:] **HEIGHT:**_____________ **WEIGHT:**_____________ **BMI:**________________

< 18.5 (underweight) 18.5 30 (normal overweight) 30.1 35 (class 1 obesity) 35.1 40 (class 2) > 40 (class 3)

INSURANCE: ☐ Private insurance ☐ Medicare (with or without supplemental insurance) ☐ MedAdvantage/HMO

DATE: ___________________

NAME: ____ **DOB:** _______________ **AGE:** _______ **GENDER:** _________

INSURANCE: ____

SURGEON: _____________ **PROCEDURE:** ___________________________________ **DATE OF SURGERY:** ___________

PRIMARY CARE PROVIDER: ____

CARDIOLOGIST: ____

OTHER PROVIDERS: ____

MEDICATION ALLERGIES & REACTIONS:

1. ____________________________ **2.** _____________________________ **3.** _____________________________

☐ **No known drug allergies** ☐ **Latex allergy** ☐ **Metal allergy**

HISTORY OF ANESTHESIA OR SURGERY COMPLICATIONS: ____

☐ Personal history of malignant hyperthermia or a difficult intubation (airway issues): _____________________

☐ Family history of malignant hyperthermia / Relationship to person: _________________________________

☐ None

Do you take any blood thinners (anticoagulants / antiplatelet medications)?

☐ No ☐ Aspirin only ☐ Yes – Medication and medical condition: ________________________________

Do you take steroids (i.e. prednisone) or "biologic" medications that affect the immune system (i.e. Plaquenil, Methotrexate)?

☐ No ☐ Yes – Medication and medical condition: ____

Have you had an infection within the past 30 days (i.e. urinary tract infection, cellulitis, pneumonia)?

☐ No ☐ Yes – Please explain: ____

Have you been hospitalized within the past 90 days? ☐ No ☐ Yes – Please explain: ____________________

Have you had a dental cleaning within the past 6 months? ☐ Yes ☐ No – Date of last cleaning: _________________

Do you have any current dental issues (gum disease, cavities, infection, etc.)? ☐ No ☐ Yes: ____________________

Have you had an injection in the affected joint within the past 90 days? ☐ No ☐ Yes – Date/Type: _________________

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS:

CARDIAC

☐ Atrial fibrillation
☐ Heart arrythmia: ___________
☐ Angina (chest pain)
☐ Congestive heart failure
☐ Abnormal EKG
☐ Heart murmur
☐ Heart valve disease
☐ Heart valve replacement

☐ Hypertension / high blood pressure
  ☐ Controlled (≤ 130/80 mmHg) ☐ Uncontrolled (≥ 130/80 mmHg)
☐ Coronary artery disease / heart disease
  ☐ Heart attack – Date: __________ ☐ Bypass surgery (CABG) – Date: _____________
☐ Cardiac stents – Date: ______________________
  ☐ > 1 year ago ☐ < 1 year ago ☐ Drug-eluting ☐ Metal
☐ Implanted devices
  ☐ Pacemaker ☐ Defibrillator ☐ Other

RESPIRATORY

☐ Asthma
☐ Emphysema
☐ Chronic obstructive pulmonary disease (COPD)

☐ Use of supplemental oxygen
☐ Obstructive sleep apnea (OSA)
  ☐ CPAP ☐ BiPAP ☐ Other / dental device ☐ None

OTHER

☐ Stroke - Date: _______________
  ☐ TIA ("mini-stroke") Date: _______________
  ☐ Ischemic (clot/blockage) ☐ Hemorrhagic (bleeding)
☐ Blood clot in LEG / deep vein thrombosis (DVT)
  Date/Treatment: ________________________________
☐ Blood clot in LUNG / pulmonary embolus (PE)
  Date/Treatment: ________________________________
☐ Anemia
☐ Bleeding disorder: ___________________________________
☐ Clotting disorder: ____________________________________
☐ Peripheral vascular or arterial disease (PVD/PAD) or
  peripheral edema (leg swelling)
☐ Aneurysm
☐ Hyperlipidemia / high cholesterol

☐ Diabetes Mellitus
  ☐ Type II --OR-- ☐ Type I
  ☐ Controlled with diet and exercise
  ☐ Controlled with oral medications only
  ☐ Controlled with oral medications + insulin/injections
  What was your last HbA1c? ____________________
  Date: ____________________
☐ Cancer - Type: _____________________________________
  Date of diagnosis: _______________________________
  Treatment: ____________________________________
  ☐ Currently in remission
☐ Gastroesophageal reflux disease (GERD)
☐ Peptic ulcer disease (PUD)
☐ Gastrointestinal (GI) bleed

RISK ASSESSMENT: TOTAL JOINT REPLACEMENT AND SPINE FUSION

☐ Hypothyroidism
☐ Hyperthyroidism
☐ Autoimmune disease (Lupus, MS, Type 1 Diabetes, etc.)
Condition: ___________________________________
☐ Neurological disorders (Parkinson's, Multiple Sclerosis, Dementia, Epilepsy, Amyotrophic Lateral Sclerosis/ALS/Lou Gehrig's disease, etc.)
Condition: ___________________________________
☐ Seizures – last seizure date: ___________________
☐ Inflammatory arthritis (Rheumatoid or Psoriatic arthritis, Ankylosing Spondylitis, etc.): ________________
☐ Gout
☐ Prior low back / lumbar fusion
☐ Other major orthopedic issues or limitations (i.e. joint pain other than the surgical site): ________________
☐ Other implanted devices (spinal cord stimulator, etc.)
Date/Type: ___________________________________

☐ Prior bariatric surgery (gastric sleeve / band / bypass)
☐ Prior organ transplant: _______________ Date: ________
☐ Chronic Kidney Disease – Stage 1-4 (if known): ________
☐ Dialysis – schedule: ____________________
☐ Kidney stones ☐ Kidney infection
☐ Liver disease
☐ Cirrhosis ☐ Hepatitis A ☐ Hepatitis B
☐ Hepatitis C: Treated? ☐ No ☐ Yes: ___________
☐ Benign prostatic hypertrophy (BPH) or other prostate issues
☐ Urinary retention
☐ Psychological or mental health disorders
☐ Depression ☐ Anxiety ☐ Other: ______
Treatment: ___________________________
☐ Well-controlled ☐ Somewhat controlled
☐ Poorly controlled
☐ Other condition: ___________________________

SUBSTANCE USE

☐ None
☐ Tobacco or nicotine use (specify type and amount/frequency) ______________________ Date of last use: ______
☐ Marijuana use (specify type and amount/frequency) ___________________________ Date of last use: ______
☐ Illegal substance use (specify type and amount/frequency) ______________________ Date of last use: ______
☐ Narcotic pain medication use (specify medication, dose/frequency, prescriber): ___________________________
☐ Alcohol use:

Women	Men
☐ < 1 drink/day and < 5 drinks/week	☐ < 2 drinks/day and < 10 drinks/week
☐ > 1 drink/day and/or > 5 drinks/week	☐ > 2 drinks/day and/or > 10 drinks/week
Specify amount/frequency: ______________	Specify amount/frequency: ______________

MRSA/MSSA SCREEN

Question	No	Yes
Do you have a history of a staph infection (MSSA or MRSA) or been told you are a carrier of this bacteria?	☐ No	☐ Yes: ____________
Have you been exposed to anyone with this type of infection (to your knowledge)?	☐ No	☐ Yes: ____________
Do you have any current or chronic skin abscesses, cellulitis, wounds, ulcers, or sores?	☐ No	☐ Yes: ____________
Do you have any chronic skin conditions such as psoriasis, rosacea, or eczema?	☐ No	☐ Yes: ____________
Are you immunocompromised (i.e. considered to have a poor immune system or at higher than average risk of infections due to certain medical conditions or medications i.e. steroids)?	☐ No	☐ Yes: ____________
Have you been hospitalized in the last year?	☐ No	☐ Yes: ____________
Have you stayed in a nursing facility in the past year?	☐ No	☐ Yes: ____________
Do you reside at a long-term care facility?	☐ No	☐ Yes
Have you been incarcerated in the past year?	☐ No	☐ Yes
Do you work in a medical setting? (hospital, clinic, nursing home, etc.)	☐ No	☐ Yes

CARDIOVASCULAR FITNESS ASSESSMENT

Question	No	Yes
Can you climb one flight of stairs without chest pain or shortness of breath?	☐ No	☐ Yes
Can you climb four flights of stairs or walk up a hill?	☐ No	☐ Yes
Can you do heavy work such as scrubbing floors or lifting or moving heavy furniture?	☐ No	☐ Yes
Do you participate in sports or have an exercise routine (walking, biking, swimming, hiking, skiing, group classes, etc.)? If yes, how often and how long do you exercise?	☐ No	☐ Yes: ____________
Do you use an assistive device such as a walker, crutches, or cane?	☐ No	☐ Yes

SOCIAL SUPPORT AND HOME ASSESSMENT

Question	No	Yes
Do you live alone?	☐ No	☐ Yes
Do you have stairs in your home?	☐ No	☐ Yes
Do you have someone dedicated to helping you with your recovery from surgery (spouse, family member, close friend)? Person/Relationship: ______________________________	☐ No	☐ Yes
Do you have someone to drive you to/from post-operative appointments and physical therapy?	☐ No	☐ Yes
Are you concerned about going home after surgery for any reason? If yes, please explain: ______________________________	☐ No	☐ Yes
Do you live within approximately a 90-minute drive to Proliance Orthopedic Associates or Valley Medical Center? If no, nearest Urgent Care/Hospital: ______________	☐ No	☐ Yes