Osseointegration Pre-Screening Questionnaire

Hello,

Thank you for your interest in our Osseointegration Program. We appreciate you taking the time to complete the following document.

Personal Information

Name (First, MI, Last): _____

Date of Birth: _____

Address:

Street: _____

City:_____ State:_____ Zip Code: _____

Email Address: _____

Mobile Number: _____ Home Number: _____

Sex: _____ Gender:_____

Preferred Language for medical terminology: _____

Emergency Contact:

Name: _____ Phone Number:_____

Relationship: _____

Are you currently employed? ☐Yes ☐No

If yes, what occupation: _____

☐ Full Time ☐ Part Time ☐ Other: _____

Living Arrangements

How many stairs to enter home: _____

How many stairs to get to:

Bedroom_____ Bathroom_____ Kitchen_____

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Home occupants:

☐ Alone

☐ Spouse/Partner

☐Other: _____

Are home occupants able to provide assistance? ☐Yes ☐No

Background

How did you hear about osseointegration? _____

How did you hear about the osseointegration program here at University of Colorado Hospital?

_____

Why are you seeking Osseointegration: _____

_____

Amputation and Prosthesis

Date of Amputation:_____

Cause of Amputation: _____

Site of Amputation: ☐Right ☐ Left ☐Both

☐Above Knee ☐Below Knee ☐ Above Elbow ☐ Below Elbow

(If both sides, provide details as needed): _____

Do you have any internal hardware in your residual limb? ☐Yes ☐ No

Prosthesis components: _____

Number of sockets used since initial amputation: _____

Any problems/concerns with your sound limb: ☐Yes ☐No _____

Mobility Aids used in prosthesis: _____

How many hours per day do you wear prosthesis? _____

If using step-counter, how many steps per day with in your prosthesis? _____

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How far can you comfortably walk **unaided**? _____

Are you currently undergoing physical therapy? ☐ Yes ☐ No

Health History

Height (inches):_____ Weight (pounds): _____

Tobacco use: ☐Yes ☐No If yes, date of last use: _____

Marijuana use: ☐Yes ☐No If yes, date of last use: _____

Alcohol use: ☐Yes ☐No If yes, how many drinks per week: _____

Past Surgical History

Previous surgeries other than amputation:

_____

_____

_____

Allergies (list with reaction): _____

_____

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Medical History

Please indicate if you have a history of any of the following. If you answer yes, please give more detail.

Yes	No	
☐	☐	Asthma
☐	☐	Peripheral neuropathy
☐	☐	Peripheral vascular disease
☐	☐	Diabetes
		☐ Type 1 ☐ Type 2
☐	☐	Cancer
☐	☐	Chemotherapy treatment
☐	☐	Radiation therapy
☐	☐	Allograft bone transplant
☐	☐	Osteoporosis
☐	☐	Systemic inflammatory disease
☐	☐	Transplant
☐	☐	Skin Infection
☐	☐	Osteomyelitis
☐	☐	Bone deformity
☐	☐	History of Fracture
☐	☐	Rheumatoid arthritis
☐	☐	Immunocompromised
☐	☐	Steroid use
☐	☐	Allergy to metal
☐	☐	Clotting disorders or Family History of clotting disorders

Medical history more detail: _____

_____

_____

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Mental Health

Have you ever suffered with depression requiring an anti-depressant: ☐Yes ☐No

If yes, are you still being treated: ☐Yes ☐No

If yes, what medication(s) was prescribed? _____

_____

_____

Pain

Do you suffer from chronic pain? ☐Yes ☐No

Do you have pain while in your prosthesis? ☐Yes ☐No

Do you have pain while out of your prosthesis? ☐Yes ☐No

If yes to any of the above, please describe: _____

_____

Do you take any medication for this pain? ☐Yes ☐No

How long have you been on this medication? _____

Who is the prescribing provider for this medication? _____

_____

Current medications

Drug (Name)	Dose (mg)	Frequency (How Often)

Are you enrolled in any clinical trials? ☐Yes ☐No

Medical Provider Contact

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Surgeon who performed amputation

Name: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Phone Number: _____ Fax: _____

Primary Care Provider

Name: _____

Address: _____

City: _____ State:_____ Zip Code: _____

Phone Number: _____ Fax: _____

Prosthetist

Name: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Phone Number: _____ Fax: _____

Physical Medicine and Rehab Physician/ Physiatrist

Name: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Phone Number:_____ Fax: _____

Pain Medicine Specialist

Name: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Phone Number:_____ Fax: _____

Osseointegration Pre-Screening Questionnaire

Have you had any recent images or your residual limb in the past five years?

XRs ☐No ☐Yes, Facility:_____ Phone:_____ Fax:_____
CTs ☐No ☐Yes, Facility:_____ Phone:_____ Fax:_____
MRIs ☐No ☐Yes, Facility:_____ Phone:_____ Fax:_____

Thank you for your time spent completing this questionnaire. We have one last request. Please sign up for My Health Connection, https://www.uchealth.org/access-my-health-connection/. My Health Connection (MHC) allows our team to streamline communication and ensure your privacy. Our patients are from all over the world and we want to be able to provide immediate communication from anywhere. Our team takes a multidisciplinary approach to your healthcare and this requires a high degree of coordination. In MHC you will be able to view upcoming appointments, send our team messages, and share valuable post-operative photos.

Ways to Return Questionnaire

Phone: 1-844-800-(LIMB) 5462
Fax: 720-553-0402
limbrestoration@uchealth.org

Anschutz Outpatient Pavilion
1635 Aurora Court
Mail Stop F722
Aurora, Colorado 80045

Thank you again for your interest in our program. Once the above steps are complete please call, 1-844-800-(LIMB) 5462, and we will schedule one on one time to review your history and discuss next steps. We look forward to hearing from you!

Sincerely,

Jason W. Stoneback, MD
Director, Limb Restoration Program
University of Colorado Hospital
Department of Orthopedics
University of Colorado School of Medicine
1-844-800-LIMB (5462)