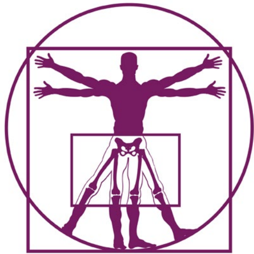

Renaissance Orthopaedics and The Bone and Joint Center at Magee-Womens Hospital
300 Halket Street, Suite 1601
Pittsburgh, PA 15213

THE BONE & JOINT CENTER
UPMC MAGEE-WOMENS HOSPITAL

Noelle DiGioia Guthrie, DO
Anthony M. DiGioia III, MD
Phone: 412-683-7272, Fax: 412-683-0341

Welcome to

The Bone and Joint Center at Magee-Womens Hospital of UPMC

Your Appointment is scheduled with:

- ○ **Noelle DiGioia Guthrie, DO**
- ○ **Anthony M. DiGioia III, MD**
- ○ **Jennifer Blassey, PA-C**

Day: _____________ Date:____________ Time: ______________

Please complete the following information and bring your insurance card(s), photo identification/driver's license and insurance copayment to your appointment.

We can speed your office visit by providing the opportunity for you to fill these forms out at home!

Thank you!

Name: ______________________ **Appointment Date:** __________

Special Notes for your doctor page:
(Comments, Questions or Reminders for the Appointment)

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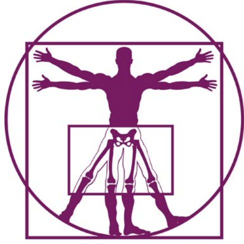

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Welcome to our office! Renaissance Orthopaedics and The Bone and Joint Center have a legacy of Patient and Family Centered Care, which is the cornerstone of the kind of care we have provided for many years. Doctors Tony and Noelle and staff are here to help guide you through the full spectrum of your orthopaedic needs.

Our location within Magee -Womens Hospital on the periphery of Oakland, and right off the Blvd of the Allies and Parkway Exit, makes the office easily accessible from all directions. For your convenience, we are located on the first floor, inside the main entrance. We are directly across from the piano in the main lobby.

Our practice is one of the most comprehensive in the region and includes a complete approach with the latest surgical techniques, special anesthesia and pain management programs and rapid rehabilitation, including a very successful same-day discharge program. Most importantly, our Care Team is 100% committed to your care and focused on meeting your needs. Our goal is to provide the best care possible for you and your family in a patient friendly environment.

We primarily treat hip and knee arthritis, specializing in total hip and total knee replacements and re-do surgeries. However, if you have other joint related complaints, you can rest assured that Dr. Noelle and the office can also review options for you.

Dr. Noelle specializes in partial knee replacement, total hip and knee replacements, revisions, and knee arthrosopy (scope) as well as general orthopaedics and robotic surgery.

We are excited for you to become a part of our practice. We want your first appointment to go as smoothly as possible. Enclosed, you will find a few pages we need you to fill out and bring with you to your first appointment. Filling this out in advance will help us better evaluate and understand your condition as well as save you time in the office.

If you have had previous treatment for the problem we will be evaluating in our office, please bring ***any relevant information*** with you or have them faxed to the office in advance. This includes any office notes, operative reports from previous surgeries, and reports from MRIs or x-rays. If you are able, please bring the disc of the MRI or x-ray if it was done outside of the UPMC system.

Also, please remember to bring your photo I.D., insurance card and copayment with you to your appointment. If applicable to your insurance, please contact your PCP for a referral. We accept all forms of payment, including cash, check, and credit/debit cards. Copayment is expected at the time of your visit.

We make every attempt to keep our office running on time. Should you find that you are unable to keep your scheduled appointment, please notify us ***at least 24 hours*** in advance.

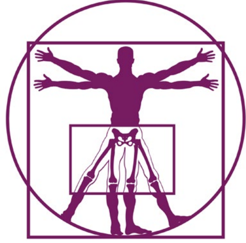
If you have any questions or would like more information, please contact our office at:

Noelle DiGioia Guthrie, DO
Anthony M. DiGioia III, MD
Phone: 412-683-7272, Fax: 412-683-0341

We look forward to seeing you!

Best wishes,

Drs. Tony DiGioia and Noelle DiGioia Guthrie



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DRIVING DIRECTIONS

From Points East (Philadelphia, Harrisburg) Via the Pennsylvania Turnpike
From the Pennsylvania Turnpike, take Exit 57 (Pittsburgh/Monroeville Exit) to I-376 West. From I-376 West, take Exit 73B (Oakland/Bates Street Exit). At the first stoplight on Bates Street, turn left onto the Boulevard of the Allies. At the first stoplight on the Boulevard of the Allies, turn right onto Halket Street. The entrance to Magee-Womens Hospital is on the left, one-half block from the intersection.

From Points Southeast
Follow Route 51 North to Liberty Tunnels. Turn right through tunnels and cross Liberty Bridge. Bear right onto ramp, heading toward Oakland. Make right onto Boulevard of the Allies. Follow Boulevard to Forbes Avenue Exit. Follow Forbes to second light, Halket Street. Make right onto Halket and follow one-half block to Magee entrance on right.

From Points West (Ohio, Pittsburgh International Airport) Via the Ohio Turnpike and Route 60
From the Pennsylvania Turnpike, take Exit 10 to Route 60 South. Follow Route 60 South past the Pittsburgh International Airport to I-279 North. Take I-279 North through the Fort Pitt Tunnel, and follow the signs to I-376 East to Forbes Ave/Oakland Exit. Follow Forbes to Halket Street. Turn right. The entrance to Magee-Womens Hospital is on the right, one-half block from the intersection.

From Points South (Washington, PA; West Virginia) Via I-79 North
Take I-79 North to Exit 59A, I-279 North. Take I-279 North through the Fort Pitt Tunnel, and follow the signs to I-376 East. Take Exit 72A (Forbes/Oakland Exit). Follow Forbes to Halket Street. Turn right. The entrance to Magee-Womens Hospital is on the right, one-half block from the intersection.

From Points North (Erie, Western New York) Via I-79
Take I-79 South to I-279 South, Exit 72, to Pittsburgh. Near downtown Pittsburgh, take Exit 2A to I-579; follow the signs that read "Monroeville." Take the Forbes Avenue/Oakland Exit; do not exit at I-376 East. Make the right turn onto the Forbes Avenue ramp. (Forbes is a one way street.) Follow Forbes to Halket Street. Turn right. The entrance to Magee-Womens Hospital is on the right, one-half block from the intersection.

From Allegheny Valley

Take Route 28 South to Highland Park Bridge. Follow signs for Washington Boulevard. Stay in right lane and bear right at first light. Continue straight onto Washington Boulevard. This becomes Fifth Avenue. Follow Fifth Avenue through Oakland, to Halket Street (one block past UPMC Montefiore). Make left onto Halket and follow one-and-one-half blocks to Magee entrance on right.

PARKING SERVICES AT MAGEE HOSPITAL

We would like to help ease your visit to our office. Here are some helpful services provided to you by Magee Hospital:

PARKING is available at the following rates for all of your office visits and any pre-testing visits **up to two hours**:

GARAGE		VALET	
0 – 1 hour	$4.00	0 – 1 hour	$7.00
1 – 2 hours	$5.00 (maximum)	1 – 2 hours	$8.00 (maximum)

****Discounted parking vouchers for any visit over two hours** and for the day of your surgery will be provided.

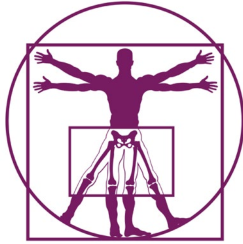
FREE PARKING will be provided for the day of discharge from the hospital following any surgical procedure.

We recommend that you take advantage of the **VALET SERVICE** available at the front entrance of the hospital when you visit us, this service will make it much easier for you and your family!

Renaissance Orthopaedics and The Bone and Joint Center are located across from the grand piano in the main lobby of Magee Womens Hospital.

The hospital also provides greeters at the **INFORMATION DESK** just inside the main entrance if you require any additional assistance or directions.

We look forward to seeing you in the office!



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Patient Information: **Date:** ______________________

Name: ________________________________ Birthdate: ____________ Social Security#: ______________________

Age: ____________ Gender: ______________ Height: __________ Weight: __________

Home Phone: ________________Cell Phone: ____________________ Email: ________________________________

Home Address: ____

Marital Status: _____________________________

Emergency Contact: Name, Relationship & Phone: ____

Are you employed? __________ Are you retired? _______

What is your Occupation? ____

Employer's Name: ____

Employer's Address: ____

Employer's Phone: ____

How did you hear about us? ____

If you are under 21 years of age or the patient is mentally incapacitated, please complete:

Guardian: _________________________ Guardian's Address: _______________________________________
____

Relationship to Patient: ____

Primary Care Physician (PCP): ____
PCP Address: ____
PCP Phone: _____________________________
PCP Fax: _______________________________

Preferred Pharmacy: ____
Phone: ________________________________

Prescription Drug Plan: ________________________________ ID#: ___________________________________

Insurance Information:
Insurance Carrier: ___________________________________ ID#: ___________________________________
Subscriber's Name: __________________________________ Subscriber's Birthdate: ___________________
Workers comp/Auto: Contact Name: _____________________ Phone:_________________________________
Claim #: ____Date of injury: ___________________________

Medical History:

Please list **ALL** medical conditions for which you currently see a Specialist for:

____
____
____

Specialist Name____
Phone_________________________________Fax____
Specialist Name____
Phone_________________________________Fax____

Have you ever been admitted to a hospital other than for surgery?   Yes or No
If Yes, Please list the reason and year if possible.

____
____

Surgical History:

Please list any operations you have had.
Please include the year, name of procedure, surgeon and hospital where it was done:

PROCEDURE   YEAR   SURGEON   HOSPITAL

____
____
____
____

Have you had any problems with anesthesia?____
Do you have any family history with anesthesia problems? _______________________________

Medications:

(Please list all current prescription and over the counter medications/vitamins/supplements)
Name: Dose: Frequency:

____
____
____
____
____

Allergies:

Penicillin Allergy: Yes   No   Adhesive Allergy: Yes   No   Nickel Allergy: Yes   No
Latex Allergy: Yes   No   Iodine Allergy: Yes   No

List any other medication and/or food allergies/reactions:

____
____

Social History:

Do you or have you used tobacco? _____ How many years_____ How many packs_____ Quit date_______

On average, how many drinks do you have in a week?   0   1-5   6-10   11-15   >16

Do you or have you ever used recreational (street) drugs? Yes   or   No
If yes, what? ________________________________   Last used? _____________________

Do you have any religious beliefs that would impact your care? _______________________________

REVIEW OF SYSTEMS

PLEASE CIRCLE ALL THAT APPLY

HEART HISTORY:

- ☐ NO HISTORY
- HIGH BLOOD PRESSURE
- CHEST PAIN (IF YES, LAST EPISODE?) ________________
- HEART ATTACK (IF SO, WHEN?) ________________
- ABNORMAL HEART RHYTHM
- HEART MURMUR
- PALPITATIONS
- MITRAL VALVE PROLAPSE
- RHEUMATIC FEVER
- BYPASS SURGERY
- HEART DISEASE
- CARDIAC CATH (DATE) _________________________
- ANGIOPLASTY (DATE) _________________________
- LAST STRESS TEST (DATE) _________________________
- ECHOCARDIOGRAM (DATE) _________________________
- CONGESTIVE HEART FAILURE
- PACEMAKER/DEFIBRILLATOR
- SWELLING OF FEET, ANKLES, HANDS

RESPIRATORY HISTORY:

- ☐ NO HISTORY
- ASTHMA
- SHORTNESS OF BREATH (REST OR ACTIVITY)
- LUNG DISEASE (COPD/EMPHYSEMA)
- CHRONIC COUGH
- COUGHING UP BLOOD
- BRONCHITIS
- PNEUMONIA
- PLEURISY
- TUBERCULOSIS
- SLEEP APNEA (CPAP/BIPAP) [WHAT SETTING?] ____ ____
- BLOOD CLOTS IN LUNGS
- USE OF OXYGEN AT HOME?
- RECENT COUGH/COLD (LAST 2 WEEKS)

KIDNEY/ENDOCRINE HISTORY:

- ☐ NO HISTORY
- DIABETES
- THYROID DISORDER
- KIDNEY FAILURE/DIALYSIS
- PANCREATITIS
- URINARY TRACT INFECTIONS
- BLOOD IN URINE
- KIDNEY STONES
- FREQUENT URINATION
- PAINFUL/BURNING URINATION
- INCONTINENCE

GASTROINTESTINAL/LIVER HISTORY:

- ☐ NO HISTORY
- HEARTBURN/ACID REFLUX
- HIATAL HERNIA
- ULCER - TYPE? ______________________
- IRRITABLE BOWEL SYNDROME
- LOSS OF APPETITE
- CHRONIC NAUSEA/VOMITING
- CHRONIC CONSTIPATION/DIARRHEA
- RECTAL BLEEDING
- HEMORRHOIDS
- CROHN'S DISEASE
- DIVERTICULOSIS
- ULCERATIVE COLITIS
- JAUNDICE
- CIRRHOSIS
- HEPATITIS - TYPE? _________________
- WHEN? _______________________

PROBLEMS WITH CIRCULATION OR BLOOD FLOW:

- ☐ NO HISTORY
- VARICOSE VEINS
- BLOOD CLOT IN LEG
- DO YOU HAVE A PERSONAL HISTORY OF BLOOD CLOTS/DVT? _________________________________
- PHLEBITIS
- ARE YOU CURRENTLY ON COUMADIN? _________________________________
- ANY FAMILY HISTORY OF BLOOD CLOTS? (IF YES, WHO?) ______________________

PLEASE CIRCLE ALL THAT APPLY

NEUROLOGICAL HISTORY:

- ☐ NO HISTORY
- STROKE (CVA)
- MINI-STROKE (TIA)
- SEIZURES/EPILEPSY
- FAINTING SPELLS
- DIZZINESS/VERTIGO
- CHRONIC HEADACHES/MIGRAINES
- BRAIN TUMOR
- MENINGITIS
- SPINAL STENOSIS
- NECK (BACK PROBLEMS)
- NUMBNESS, TINGLING, WEAKNESS IN EXTREMITIES (WHERE?) ____________________
- TREMORS
- MUSCLE/NERVE DISORDERS
- HEAD INJURY
- PARALYSIS

SKIN HISTORY:

- ☐ NO HISTORY
- ECZEMA
- PSORIASIS
- RASH/ITCH
- OPEN SORES
- CHANGE IN SKIN COLOR
- CHANGE IN HAIR OR NAIL

EYES/EARS/NOSE/THROAT HISTORY:

- ☐ NO HISTORY
- CATARACTS ☐ RIGHT ☐ LEFT
- GLAUCOMA ☐ RIGHT ☐ LEFT
- MACULAR DEGENERATION ☐ RIGHT ☐ LEFT
- RETINOPATHY ☐ RIGHT ☐ LEFT
- WEAR CONTACTS/GLASSES
- HEARING LOSS/RINGING IN EARS
- USE HEARING AID ☐ RIGHT ☐ LEFT
- CHRONIC EARACHES/DRAINAGE
- CHRONIC SINUS PROBLEMS/DRAINAGE
- VOICE HOARSENESS/DIFFICULTY SPEAKING
- SWOLLEN GLANDS IN NECK
- JAW PAIN/TMJ/INJURY
- LOOSE, CHIPPED, CAPPED TEETH, DENTURES, BONDS, VENEERS

MUSCULOSKELETAL HISTORY:

- ☐ NO HISTORY
- ARTHRITIS
- FRACTURES? ____________________
- MUSCLE DISEASE? ____________________
- OSTEOPOROSIS
- GOUT
- ARTIFICIAL JOINT – TYPE? __________
- JOINT PAIN
- JOINT STIFFNESS/SWELLING
- CARPAL TUNNEL

HEMATOLOGY (BLOOD) HISTORY:

- ☐ NO HISTORY
- HIV/AIDS
- ANEMIA
- BLOOD TRANSFUSION
- SICKLE CELL TRAIT/DISEASE
- BLEEDING DISORDER
- EASY BRUISING
- BLEEDING GUMS
- NOSE BLEEDS
- BLEED EASILY OR TAKE LONG TIME TO HEAL

PLEASE CIRCLE ALL THAT APPLY

REPRODUCTIVE (WOMAN) HISTORY:

- ☐ NO HISTORY
- ABNORMAL MAMMOGRAM
- ABNORMAL PAP SMEAR
- BREAST CYSTS
- FIBROIDS
- COULD YOU BE PREGNANT? _______________
- LAST MENSTRUAL PERIOD? _______________
- ARE YOU POST MENOPAUSAL? _____________

REPRODUCTIVE (MAN) HISTORY:

- ☐ NO HISTORY
- ENLARGED PROSTATE
- ELEVATED PSA
- PROSTATITIS

PSYCHOSOCIAL HISTORY:

- ☐ NO HISTORY
- ALZHEIMER'S
- ANXIETY DISORDER
- DEPRESSION
- BIPOLAR DISORDER
- MEMORY LOSS OR CONFUSION

CANCER HISTORY:

- ☐ NO HISTORY
- TYPE ____
- LOCATION _____________________________________
- TREATMENT ___________________________________

IMMUNIZATION HISTORY AND LAST SHOT:

FLU ____________________ TETANUS ____________________

SHINGLES ____________________ PNEUMONIA ____________________

PAIN HISTORY (FOR YOUR KNEE OR HIP):

LOCATION: ____________________

FOR HOW LONG (YEARS/MONTHS)?: ____________________

DOES THE PAIN RADIATE?: __________ IF SO, WHERE?: ____________________

WHAT MAKES THE PAIN WORSE?: ____________________

WHAT MAKES THE PAIN BETTER?: ____________________

RATE THE PAIN. WHAT IS IT MOST OF THE TIME? 1 2 3 4 5 6 7 8 9 10
(SLIGHT ………………. MODERATE ……………. SEVERE)

WHAT KIND OF PAIN IS IT?: ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING

ANY PREVIOUS INJURIES/SURGERIES TO YOUR JOINT?: ____________________

SOCIAL WORK ASSESSMENT

YOUR HOME ENVIRONMENT:

WHO LIVES WITH YOU? ____________________ ARE THEY HEALTHY AND ABLE TO ASSIST YOU? __________

WHO CAN HELP YOU AFTER SURGERY? (LOCAL, FAMILY, & FRIENDS) ____________________

DO YOU HAVE ANY CONCERNS SUCH AS FAMILY, FINANCES, HOUSING, MENTAL HEALTH AND/OR DOMESTIC VIOLENCE?

☐ YES ☐ NO OTHER: ____________________

DO YOU HAVE ANY PROBLEMS COMMUNICATING? IF YES, EXPLAIN: ____________________

HAVE YOU HAD JOINT REPLACEMENT BEFORE? YES NO

- IF YES, WHICH JOINT/SIDE & WHEN? ____________________

DID YOU RETURN HOME AFTER SURGERY? YES NO

IF NOT, WHERE DID YOU GO?____________________

STEPS:

EXTERIOR ON APPROACH: NONE ____ NUMBER OF STEPS RAILINGS? YES NO

INTERIOR BASEMENT TO 1ST FLOOR: NONE ____ NUMBER OF STEPS RAILINGS? YES NO

INTERIOR 1ST FLOOR TO 2ND FLOOR, ETC: NONE ____ NUMBER OF STEPS RAILINGS? YES NO

WILL YOU HAVE ASSISTANCE USING THE STAIRS IMMEDIATELY AFTER SURGERY? YES NO

1ST FLOOR BATHROOM/POWDER ROOM? YES NO 1ST FLOOR BEDROOM? YES NO

PLEASE CIRCLE STYLE OF YOU HOME: APT. CONDO/TOWNHOUSE SPLIT LEVEL 1 STORY 2 STORY OTHER ________

MEDICAL EQUIPMENT:

CIRCLE ANY OF THE FOLLOWING EQUIPMENT YOU ALREADY OWN: (*CANE WALKER WHEELCHAIR BEDSIDE TOILET SHOWER CHAIR CRUTCHES RAISED TOILET SEAT STAIR GLIDE CHAIRLIFT OTHER:* ____________________

DO YOU DRIVE? YES NO IF NOT, WHO TRANSPORTS YOU? ____________________

ARE YOU INDEPENDENT WITH ACTIVITIES? YES NO

DO YOU USE COMMUNITY RESOURCES SUCH AS: (*MEALS ON WHEELS LIFELINE ACCESS TRANSPORTATION PRIVATE CAREGIVERS AREA AGENCY ON AGING OTHER* ____________________

ARE YOU INTERESTED IN INFORMATION REGARDING ANY OF THE ABOVE? YES NO

HOME CARE AGENCY PREFERENCE:

☐ NO PREFERENCE ☐ UPMC OTHER ____________

DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL/POWER OF ATTORNEY)? YES NO

- IF YES, BRING IT WITH YOU THE **DAY OF SURGERY**

- IF NO, WOULD YOU LIKE TO RECEIVE INFORMATION? YES NO

FAMILY MEDICAL HISTORY:

	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH
FATHER	____	____________	____________
MOTHER	____	____________	____________
SIBLINGS	____	____________	____________
	____	____________	____________
	____	____________	____________
	____	____________	____________
SPOUSE	____	____________	____________
CHILDREN	____	____________	____________

PLEASE READ AND SIGN THE INSURANCE AUTHORIZATION

COMMERCIAL INSURANCE: REQUIRED FOR ALL COMMERCIAL CARRIERS EXCLUDING WORKMAN'S COMPENSATION AND AUTO CARRIERS:

I AUTHORIZE RENAISSANCE ORTHOPAEDICS TO RELEASE TO MY INSURANCE COMPANY ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIM. I HEREBY AUTHORIZE PAYMENT TO RENAISSANCE ORTHOPAEDICS OF ANY BENEFIT DUE ME UNDER MY INSURANCE PLAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR NON-COVERED CHARGES. THIS AUTHORIZATION OR COPY OF IT SHALL BE VALID FOR 12 MONTHS.

I ALSO AUTHORIZE RENAISSANCE ORTHOPAEDICS TO DISCLOSE MY PROTECTED HEALTH INFORMATION (PHI) FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO).

SIGNATURE: ____ DATE: ______________________

MEDICARE AUTHORIZATION:

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION OR OTHER INFORMATION TO PROVIDE TO THE MEDICARE PROGRAM AND/OR ANY OF MY INSURANCE CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED CLAIM. I REQUEST PAYMENT BE MADE DIRECTLY TO THE PROVIDER.

I ALSO AUTHORIZE RENAISSANCE ORTHOPAEDICS TO DISCLOSE MY PROTECTED HEALTH INFORMATION (PHI) FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO).

SIGNATURE: ____ DATE: ______________________

Please complete all pages and bring your insurance card(s), photo identification/driver's license and insurance copayment to your appointment.

All of these items are required to be treated by your care providers at Renaissance Orthopaedics and The Bone and Joint Center.