THE CENTER
ORTHOPEDIC & NEUROSURGICAL
CARE & RESEARCH

HIP & KNEE

For Office Use Only: Provider #_____
MRN #_____ Staff Initials _____

Appointment Date: _____/_____/_____ Name: _____

Date of Birth: _____/_____/_____ Age: _____ PCP: _____

Who referred you today? ❑ Self ❑ Friend ❑ Provider: _____

PLEASE CHECK YES OR NO IF YOU ARE FREQUENTLY BOTHERED BY, OR HAVE RECEIVED TREATMENT FOR:

Bleed Easily	Yes ❑ No ❑	Taking Blood Thinners	Yes ❑ No ❑	Surgical Complications	Yes ❑ No ❑
Blood Clots	Yes ❑ No ❑	Difficulty with Anesthesia	Yes ❑ No ❑	History of Infection	Yes ❑ No ❑
Allergic to metal	Yes ❑ No ❑				

Reason for seeing the doctor today _____

Problem with: ❑ Hip ❑ Knee ❑ Right ❑ Left Does your ankle hurt: ❑ Yes ❑ No

Do you have a specific injury? ❑ Yes ❑ No If so, what occured _____

_____

Where did your injury occur (work, home, motor vehicle accident, etc.)? _____

If this was work related, did you file a work comp form? ❑ Yes ❑ No

If not an injury, was the onset sudden or gradual? _____

Date problem began: _____

If you have a limp, is it: ❑ Slight ❑ Moderate ❑ Severe

Rate your pain over the past week. ***Please circle the number that applies to your pain level.***

Least 1 2 3 4 5 6 7 8 9 10 Worst

What makes your pain worse? ❑ Uneven Ground ❑ Level Ground ❑ Going Upstairs ❑ Going Downstairs ❑ Sitting ❑ Walking ❑ Running ❑ Jumping ❑ Sports

How long can you perform activities without pain?

Sitting: ❑ 30 Minutes ❑ 1/2-1 Hour ❑ 1-2 Hours ❑ 2-4 Hours ❑ Unlimited

Standing: ❑ 30 Minutes ❑ 1/2-1 Hour ❑ 1-2 Hours ❑ 2-4 Hours ❑ Unlimited

If this is a knee problem, are you having any of the following symptoms?

Swelling	Yes ❑ No ❑
Popping/grinding	Yes ❑ No ❑
Catching	Yes ❑ No ❑
Buckling	Yes ❑ No ❑
Pain in the knee	Yes ❑ No ❑
Pain in the knee at night	Yes ❑ No ❑
Pain with stairs or squats	Yes ❑ No ❑
Knee is bowed	Yes ❑ No ❑

PLEASE COMPLETE BACK OF FORM

Do you need an assistive device when you walk outside? ❑ None ❑ Cane for long walks ❑ Cane most of the time

❑ One crutch ❑ Two crutches/walker ❑ Unable to walk

How far are you able to walk? ❑ None, bed to chair only ❑ Indoors only ❑ 2-3 Blocks ❑ 6 Blocks ❑ Unlimited distance

Can you climb stairs? ❑ Normal (alternate feet) without railing ❑ Normal with railing ❑ Unable to do stairs

Can you put on your shoes and socks independently? ❑ With ease ❑ With difficulty ❑ Unable to do

Do you have any difficulty crossing your legs? ❑ Yes ❑ No

TREATMENT HISTORY

Have you previously seen an M.D. for this problem? ❑ Yes ❑ No

If so, who and when? _____

Do you use inserts in your shoes or braces? ❑ Yes ❑ No If so, do they help? ❑ A little ❑ A lot ❑ Not at all ❑ Make you feel worse

Have you ever had hip or knee surgery? ❑ Yes ❑ No If yes, where and when was this done? _____

What was the procedure? _____

Have you tried any of the following to treat your pain?		Did it help?
Ice	Yes ❑ No ❑	Yes ❑ No ❑
Exerscise	Yes ❑ No ❑	Yes ❑ No ❑
Physical Therapy	Yes ❑ No ❑	Yes ❑ No ❑
Previous Injections	Yes ❑ No ❑	Yes ❑ No ❑
Pain in the knee	Yes ❑ No ❑	Yes ❑ No ❑
Heat	Yes ❑ No ❑	Yes ❑ No ❑
Rest	Yes ❑ No ❑	Yes ❑ No ❑
Medication	Yes ❑ No ❑	Yes ❑ No ❑