ORTHOSURGERY
Ιατρείο Ορθοπαιδικών Παθήσεων

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INITIAL KNEE CONSULTATION

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NAME: ____________________________________ AGE: _______ DATE: _____________

SEX: MALE FEMALE HAND DOMINANCE: RIGHT LEFT

HEIGHT: _________ WEIGHT: ________ SOCIAL SECURITY NO: ____ - ___ - ____

INSURANCE: ___________________________________ POLICY NO: ____________________

REFERRED BY: ______________________________ PHONE NO: ______________________

HOSPITAL/ ADDRESS: ____

Which knee: Right Left

Date of onset OR length of symptoms: _________________

Prior injuries to this knee: YES NO

If yes, please describe:

____

Please describe how your symptoms began (traumatic/injury OR gradual/unknown onset):

____

____

____Location of pain:

front of knee inner knee outer knee all over

If 100% were normal, as of today what percentage would you give your knee as a grade?

____

Pain at rest (1 least - 10 greatest) _________

Pain with activity (scale 1-10) _________

Pain at night YES NO

Activities that make the pain better:

____

Activities that make the pain worse:

____

Swelling YES NO

Type of Pain: Sharp Dull Throbbing Numbness Shooting Burning Tingling

Nature of Pain: Constant Frequent Occasional Intermittent

Since onset, is the pain getting: Better Worse

Does the pain radiate? Yes No

If yes, where: Groin Back Hip Thigh Calf Foot

Symptoms are worse in: Morning Afternoon Night Same all day

Any mechanical symptoms: None Popping Clicking Locking Giving way Instability

Do you feel that you limp: No limp Slight Moderate Severe

Do you use assistive devices: None Cane Crutches Walker Wheelchair

How far can you walk before limited by pain: Unlimited Indoor only Less than 2 blocks 2-10 blocks More than 10 blocks (30 minutes) Unable to walk

Difficulty with stairs: None Normal going up, difficult going down One at a time Need to hold banister Unable to walk up stairs

Can you sit comfortably: Unlimited Less than 1 hour Severe discomfort Discomfort arising from chair

Have you seen anyone for this problem Yes No

If yes, who: Family doctor Orthopaedic Surgeon Therapist Other: ____________________

Name, Location, Phone ____

Type of Treatment

____

Did your symptoms improve after: Yes No

Please describe: ____

Please describe your hobbies/ activities:

____

____

REVIEW OF SYSTEMS

HEENT (Head, Ears, Eyes, Nose, and Throat):

Normal Headaches Glaucoma

Cataracts Dental Problems Sinusitis

PULMONARY (Lungs):

Normal Asthma COPD Shortness of Breath

CARDIOVASCULAR (Heart):

Normal Chest Pain Palpitations Previous Heart Surgery Abnormal rhythm

NEUROLOGIC:

Normal Stroke Seizure Headaches Motor/Sensory Deficit

GASTROINTESTINAL:

Normal Stomach pain with NSAIDs (Motrin, Ibuprofen) Ulcer Heartburn

GI/Rectal Bleed Adverse reaction to NSAIDs: _______________

GENITOURINARY:

Normal Frequent night-time urination Prostate

Incontinence Burning with urination

SKIN:

Normal Skin rash Psoriasis

MUSCULOSKELETAL

Normal except shoulder   Other joint pains: location _______________

PAST MEDICAL HISTORY

Please list any Medical Illnesses (i.e. diabetes, high blood pressure, etc…)

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

List any prior surgeries

Type of Surgery Year Hospital – Surgeon

1. ____

2. ____

3. ____

4. ____

List any allergies to medications

Medication Side Effect

1. ____

2. ____

3. ____

List current medications being taken on a regular basis (include dose and how often)

1. _____________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

FAMILY HISTORY

Father   Living Any medical problems: _______________________

Deceased – at age _____ Cause: ______________________________

Mother   Living Any medical problems: ________________________

Deceased – at age _____ Cause: ______________________________

Siblings: Number _______ Any medical problems: ___________________________

SOCIAL HISTORY

Marital Status: Married   Single   Divorced

Number of children: __________

Do you smoke?   No   Yes – If so how many packs per day: __________

Do you drink alcohol?   No   Occasionally   Daily

Employment

Type of work: ____

Currently working: Yes No

If not working:

Are you temporarily unemployed off work – how long________

Any heavy lifting involved with work: Yes No

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

____

Signature of Patient or Parent of Minor

____

Date