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