

Knee Joint Patient History

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14137

Medical Record Number

10 digit grid for Medical Record Number

Date of Visit

MM/DD/YYYY grid for Date of Visit

First Name

15 digit grid for First Name

Middle

3 digit grid for Middle

Last Name

20 digit grid for Last Name

Suffix Sr. Jr. III IV M.D. PhD

Date of Birth

MM/DD/YYYY grid for Date of Birth with labels: month, day, year (4 digit ex. 1922)

Gender

Female Male

Race

African American Asian Caucasian Hispanic Native American Other _____

Marital Status

Single Married Living with significant other Divorced Separated Widowed

Location of Problem

Right knee Left knee

If you are seeing us for more than one problem, which ONE is the worst?

Right knee Left knee

Please describe your current problem (If you are seeing the doctor for multiple problems, answer for the most severe)

- New Injury or problem (less than 6 weeks duration)
- Subacute problem (began slowly with no identifiable cause and progressively worsened)
- Chronic problem (problem has been present over time period of more than 3 months and never been restored to normal)
- Re-injury (you injured this same area before, received treatment, had no problems until this new injury occurred)

Date problem began (approximate if unsure)

MM/DD/YYYY grid for Date problem began

Date of re-injury

MM/DD/YYYY grid for Date of re-injury

Is your problem a result of an injury? Yes No

ANSWER THE QUESTIONS IN THIS BOX ONLY IF YOUR PROBLEM IS THE RESULT OF AN INJURY

If your problem is the result of an injury, where did it occur? (check one answer only)

Home Work Motor vehicle accident Exercise Sport Competition Other (specify) _____

What caused your injury?

- Fall Fighting
- Lifting Twisting
- Throwing Collision/Contact
- Reaching Other (specify) _____
- Pulling

Check any of the following that happened at the time of your injury

Felt pain Heard popping Had swelling Dislocation Fracture Other (specify) _____

Have you talked to a lawyer about today's problem? Yes No

Are you receiving or have you applied for workers compensation concerning your injury? Yes No

Have you received previous treatment for your current problem? Yes No

If yes, please specify treatment type (**check all that apply**) and provide the **# of the procedures** or **weeks of physical therapy** you have had for the specific problem you are seeing the doctor for today

- ER Visit chiropractic
- oral medicine massage therapy
- physical therapy # of weeks acupuncture
- surgical # of surgeries other _____
- injections # of injections (specify)

Please tell us your height and weight

Height

ft inches

Weight

pounds



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·Please check any of the following conditions you have or have had in the past.
·If you are unsure, please ask a staff member to assist you in filling out this form.

You may check more than one condition.

Medical Condition History Check this box if you have **no** medical problems no medical problems

- Alcoholism
- Anemia
- Anxiety
- Asthma
- Arthritis - rheumatoid (verified with blood test)
- Arthritis - osteo, degenerative
- Blood Clot Year
- Blood Transfusion Year
- Bowel disease
- Cancer (specify) _____
- Cardiac Arrhythmia (Abnormal heart rate)
- Congestive Heart Failure
- Coronary Artery Disease (Angina)
- Cerebrovascular Disease (Stroke)
- COPD (Chronic Obstructive Pulmonary Disease)
- Diabetes
- Depression
- Fibromyalgia
- GERD
- Gout
- Heart Attack Year
- Hypertension (High Blood Pressure)
- Hypercholesterolemia (Elevated Cholesterol)
- Hypothyroidism
- Kidney Disease
- Liver Disorder - Cirrhosis
- Liver Disorder - Hepatitis
- Lung Disease
- Osteomyelitis
- Parkinson's
- Ulcer Disease
- Other (specify all other) _____

Surgery/ Procedures These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

Have you ever had surgery? Yes No **Year**

Ear, Nose, Throat Surgeries

- Deviated Septum -----
- Sinus Repair -----
- Tonsillectomy -----
- Tracheostomy -----
- Vocal Cord Surgery -----

Gastrointestinal Surgeries

- Appendectomy -----
- Cholecystectomy (Gallbladder removed) -----
- Colon Resection -----
- Exploratory Laparoscopy -----
- Hernia -----
- Femoral Incisional Inguinal Umbilical
- Liver Resection -----
- Small Bowel Obstruction Repair -----
- Splenectomy -----

Gynecologic Surgeries

- Hysterectomy -----
- Oophorectomy -----
- Ruptured ectopic -----
- Laparoscopy -----
- C-Section -----

Urologic Surgeries

- Bladder Suspension -----
- Bladder Removed -----
- Lithotripsy (Stone Machine) -----
- Prostatectomy (Prostate Removed) -----
- Vasectomy -----

General Surgeries

- Breast Biopsy -- Right Left Bilateral -----
- Mastectomy -- Right Left Bilateral -----
- Thyroid Surgery -----
- Whipple -----

Heart (Cardiac) Surgeries

- CABG_ # arteries 1 2 3 4 4+ -----
- Valve -- Aortic Mitral Tricuspid -----
- Angioplasty -----
- Defibrillator -----
- Pace Maker -----

Vascular Surgeries

- Bypass Graft - Legs -----
- Vascular Access -----
- AAA -----
- Thoracic Aneurysm -----

Thoracic Surgeries

- Chest Tube -----
- Pulmonary -----
- Pectus -----

Neurosurgeries

- Brain Tumor ----- Malignant Benign -----
- Brain Aneurysm -----
- Chiari Decompression -----
- Spinal Cord Tumor_ Malignant Benign -----
- Epidural Injection -----
- Abscess -----
- Stent -----



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Orthopaedic Surgery/ Procedures

Please check any procedures you have had and give the year.

Most Recent Year

Previous Surgery Year

(if same surgery performed more than once)

Broken Bones/Fracture Repair Surgeries

- Fracture Repair - Finger ----- Right Left Bilateral -----

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- Fracture Repair - Hand ----- Right Left Bilateral -----

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- Fracture Repair - Wrist ----- Right Left Bilateral -----

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- Fracture Repair - Arm ----- Right Left Bilateral -----

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- Fracture Repair - Elbow ----- Right Left Bilateral -----

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- Fracture Repair - Shoulder ----- Right Left Bilateral -----

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- Fracture Repair - Hip/Pelvis ----- Right Left Bilateral -----

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- Fracture Repair - Femur ----- Right Left Bilateral -----

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- Fracture Repair - Knee ----- Right Left Bilateral -----

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- Fracture Repair - Lower Leg ----- Right Left Bilateral -----

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- Fracture Repair - Ankle/Foot ----- Right Left Bilateral -----

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Ankle/Foot Surgeries

- Ankle Arthroscopy ----- Right Left Bilateral -----

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- Ankle Fusion ----- Right Left Bilateral -----

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- Tendon Surgery ----- Right Left Bilateral -----

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- Toe Surgery specify _____ ----- Right Left Bilateral -----

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Elbow, Wrist, Hand Surgeries

- Biceps Repair ----- Right Left Bilateral -----

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- Carpal Tunnel Surgery ----- Right Left Bilateral -----

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- Elbow Arthroscopy ----- Right Left Bilateral -----

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- Elbow Ligament Reconstruction ----- Right Left Bilateral -----

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- Elbow Replacement ----- Right Left Bilateral -----

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- Hand Tendon Repair ----- Right Left Bilateral -----

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- Nail Bed Surgery ----- Right Left Bilateral -----

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- Tennis Elbow Surgery ----- Right Left Bilateral -----

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- Trigger Finger Surgery ----- Right Left Bilateral -----

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- Wrist Ligament Reconstruction ----- Right Left Bilateral -----

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Knee Surgeries

- Knee Arthroscopy ----- Right Left Bilateral -----

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- Cartilage surgery/meniscus surgery ----- Right Left Bilateral -----

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- Knee replacement ----- Right Left Bilateral -----

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- Ligament reconstruction - ACL ----- Right Left Bilateral -----

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- Ligament reconstruction - other ----- Right Left Bilateral -----

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Hip Surgeries

- Hip replacement ----- Right Left Bilateral -----

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- AVN Surgery Core Decompression Fibular Graft Right Left Bilateral -----

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Shoulder Surgeries

- Shoulder Arthroscopy ----- Right Left Bilateral -----

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- Rotator cuff surgery ----- Right Left Bilateral -----

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- Shoulder replacement ----- Right Left Bilateral -----

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- Shoulder stabilization ----- Right Left Bilateral -----

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Spine Surgeries

- Laminectomy ----- Cervical Lumbar Thoracic -----

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- Anterior Fusion ----- Cervical Lumbar Thoracic -----

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- Posterior Fusion ----- Cervical Lumbar Thoracic -----

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- Posterior Discectomy ----- Cervical Lumbar Thoracic -----

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Other (List all other surgeries) _____



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Drug Allergy and Medication Information

Have you ever had problems with anesthesia? Yes No *If yes, describe* _____

Are you allergic to latex? Yes No

Are you allergic to any medications? Yes No *If yes, please write the name of the drug in the boxes below and check the reaction you experienced. Please write only one drug in each space provided. If you have more than 3 drug allergies list the others in the space provided.*

Specify Drug:

Describe: shock breathing problems rash nausea other _____

Specify Drug:

Describe: shock breathing problems rash nausea other _____

Specify Drug:

Describe: shock breathing problems rash nausea other _____

Please list additional drug allergies here: _____

List all medications you are currently taking with the correct dosage and frequency (prescription and non-prescription medication)

Please check any of the medications listed below which you have taken in the past.

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Advil | <input type="checkbox"/> Indocin |
| <input type="checkbox"/> Aleve | <input type="checkbox"/> Lodine |
| <input type="checkbox"/> Arthrotec | <input type="checkbox"/> Naprelan |
| <input type="checkbox"/> Bextra | <input type="checkbox"/> Naproxen |
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Oruval/Orudis |
| <input type="checkbox"/> Daypro | <input type="checkbox"/> Ultram |
| <input type="checkbox"/> Ibuprofen | |

Please check any of the following side effects you experienced while taking any of the above anti-inflammatory medications.

nausea diarrhea gastric ulcers upset stomach vomiting other _____

Please check any of the following medications you take on a regular basis.

- Aspirin Axid Coumadin Cytotec Heparin Maalox Mylanta Pepcid Prevacid Prilosec Tagamet Zantac

Family Medical History

Please check all diseases for which you have a family history:

- | | |
|--|--|
| <input type="checkbox"/> Cancer - Breast | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer - Prostate | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer - Other | <input type="checkbox"/> Arthritis - osteo, degenerative |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lupus |

If you know your parents' health history please provide the information below. Otherwise, please leave blank.

Father <input type="radio"/> alive <input type="radio"/> deceased	Age (current age or age deceased) <input type="text"/>	Health history	<input type="checkbox"/> cancer	<input type="checkbox"/> rheumatoid arthritis
			<input type="checkbox"/> heart disease	<input type="checkbox"/> osteoarthritis
Cause of death (if deceased)	<input type="text"/>		<input type="checkbox"/> stroke	<input type="checkbox"/> gout
			<input type="checkbox"/> diabetes	<input type="checkbox"/> lupus

Mother <input type="radio"/> alive <input type="radio"/> deceased	Age (current age or age deceased) <input type="text"/>	Health history	<input type="checkbox"/> cancer	<input type="checkbox"/> rheumatoid arthritis
			<input type="checkbox"/> heart disease	<input type="checkbox"/> osteoarthritis
Cause of death (if deceased)	<input type="text"/>		<input type="checkbox"/> stroke	<input type="checkbox"/> gout
			<input type="checkbox"/> diabetes	<input type="checkbox"/> lupus

Knee Society Evaluation

Please answer the following questions to the best of your ability. Select the one answer that best describes your situation. Check **ONLY ONE** answer for each question. If you have any questions, the nurse will be happy to assist you.

How would you rate your knee today as a percentage of normal (0% - 100%, with 100% being normal)? %

A. Knee Evaluation**1. Pain**

Please describe your pain

- none
- mild or occasional
- mild or occasional stairs only
- mild or occasional walking and stairs
- moderate occasional
- marked
- moderate continual
- severe

B. Function**1. Walking**

Please describe the distance you are able to walk

- I am not limited in the distance I can walk
- I am limited in the distance I can walk >10 blocks
- I am limited in the distance I can walk to 5-10 blocks
- I am limited in the distance I can walk to <5 blocks
- I am housebound in my walking
- I am unable to walk

2. Stairs

Please describe your ability to climb stairs

- I am able to climb stairs normally up and down
- I am able to climb stairs normally down with the rail
- I climb stairs up and down with the use of the rail
- I climb stairs up with the use of the rail can not go down stairs
- I am unable to climb stairs

3. Support

Please describe the assistance you require

- none
- I use a cane
- I use two canes
- I use two crutches/walker

Have you had knee replacement surgery? No Yes

If you have had knee replacement surgery please answer the next 2 questions

Overall, what is your level of satisfaction with knee replacement surgery?

- Extremely satisfied
- Very satisfied
- Moderately satisfied
- Slightly satisfied
- Not at all satisfied

If you could, would you choose again to have this surgery performed on your Knee?

- No
- Yes



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SF-12 - Check ONLY ONE answer for each question

Instructions: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

(#2 and #3) The following items are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

- | | <u>Yes,
Limited
A Lot</u> | <u>Yes,
Limited
A Little</u> | <u>No, Not
Limited
At All</u> |
|--|-----------------------------------|--------------------------------------|---------------------------------------|
| 2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Climbing several flights of stairs | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

(#4 and #5) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 4. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 5. Were limited in the kind of work or other activities | <input type="radio"/> 1 | <input type="radio"/> 2 |

(#6 and #7) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 6. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 7. Didn't do work or perform other activities as carefully as usual | <input type="radio"/> 1 | <input type="radio"/> 2 |

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

(#9, #10 and #11) These questions are about how you feel and how things have been with you during the past 4 weeks.

For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks

- | | <u>All
of the
time</u> | <u>Most
of the
time</u> | <u>A good
bit of
time</u> | <u>Some
of the
time</u> | <u>A little
of the
time</u> | <u>None
of the
time</u> |
|---|--------------------------------|---------------------------------|-----------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| 9. Have you felt calm and peaceful? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 10. Did you have a lot of energy? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 11. Have you felt downhearted and blue? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |

12. During the past 4 weeks, how much of the time has your physical or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)?

- | <u>All
of the
time</u> | <u>Most
of the
time</u> | <u>Some
of the
time</u> | <u>A little
of the
time</u> | <u>None
of the
time</u> |
|--------------------------------|---------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |

PLEASE RETURN THIS COMPLETED PACKET TO THE FRONT DESK NOW