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Patient Name:_____ Date of Birth_____ DATE_____

Referring Doctor Name _____
Address_____
Phone #_____

What is the reason for your visit?

_____
_____

Where is your pain? □ Right Hip □Left Hip □Right Knee □Left Knee □Other_____

How long have you had this pain?_____

If you are having hip pain where is it located ?

□ Groin □ Side of Hip □Thigh □Down the leg

If you are having Knee pain where is it located?

□The inside of the knee □The outside of the knee □ The front of the knee □ The back of the knee

How would you describe your pain ?

□ Sharp □ Dull □ Throbbing □ Burning □ Shooting □ Tingling

The Pain is: □ Getting worse □ Getting better □ Staying the same

The pain is: □ Constant □ Intermittent

Do you have pain when you:

□ Walk □ Stand □ Sit □ At night

Rate your pain 1-10 ( 1 is minimal pain and 10 is severe pain ) _____

Do you have any of the following?

□ Stiffness □ Swelling □Numbness □Weakness

How far can you walk before you have pain?

□ Unlimited □ 1-2 blocks □ 2-3 blocks □ household only □ Bed to chair □ Unable

Do you use any assistive devices?

□ Cane □ Walker □ Wheel chair □ None

Do you have difficulty with stairs? □ Yes □ No

Do you have difficulty putting on shoes and socks ?

□ None □ With difficulty □ Unable

Have you tried any of these medications?

□Tylenol □Ibuprofen □Alleve □Celebrex □Aspirin □ Other_____

Have you tried an injection? □ YES □ NO

What kind of Injection? □ Steroid □ Gel Shot □PRP □ Don't know

How many injections have you had?_____ When was your last injection ?_____

Have you tried physical therapy or exercises ? □ YES □ No

**PAST MEDICAL HISTORY**

Heart Disease □YES □NO Details_____

Blood clots □YES □NO Details_____

Sleep Apnea □YES □NO Details_____

Diabetes □YES □NO Details_____

High Blood Pressure □YES □NO Details_____

OTHERS_____

**PAST SURGICAL HISTORY**

| **Name of Surgery** | **Surgeon** | **Hospital** | **Date** |
|---|---|---|---|

_____

_____

_____

**ALLERGIES**

Do you have any allergies to medications?_____

Do you have any metal allergies?_____

**CURRENT MEDICATIONS**

_____

_____

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**SOCIAL HISTORY**

What type of work do you do?

□ Homemaker □Retired □ On disability □Manual labor □ Desk Job □ Occupation ____

Marital Status: □ Single □ Married □Divorced □ Widowed

Do you live alone? □YES □ NO Who Do you live with? _____

Do you Drink Alcohol ? □YES □ NO If yes how many drinks/ week ? _____

Do you smoke or use tobacco? □YES □NO If yes how many packs/day? _____

Do You use illicit Drugs? □YES □ NO Describe _____

What are your hobbies / activities that you enjoy ?

□ Walking □ Running □ Golf □ Swimming □ Skiing □ Gardening □ Other_____

**FAMILY MEDICAL HISTORY**

| Member | Alive/Deceased | Age | Health / Cause of death |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Sibling | | | |
| Sibling | | | |

**REVIEW OF MEDICAL SYSTEMS**

| | | | | | |
|---|---|---|---|---|---|
| **Constitutional** | | | **Musculoskeletal** | | |
| Weight loss | □YES | □ NO | Rheumatoid Arthritis | □YES | □ NO |
| Recent Fevers | □YES | □ NO | Ankylosing Spondylitis | □YES | □ NO |
| | | | Lupus | □YES | □ NO |
| **Eyes** | | | Osteoporosis | □YES | □ NO |
| Glasses | □YES | □ NO | Pagets | □YES | □ NO |
| Cataracts | □YES | □ NO | | | |
| Glaucoma | □YES | □ NO | **Skin** | | |
| | | | Psoriasis | □YES | □ NO |
| **Ear/Nose/Throat** | | | Eczema | □YES | □ NO |
| Sinus Problems | □YES | □ NO | Dermatitis | □YES | □ NO |
| Dental Problems | □YES | □ NO | | | |
| | | | **Neurologic** | | |
| **Cardiovascular** | | | Seizures | □YES | □ NO |
| Heart attack | □YES | □ NO | Polio | □YES | □ NO |
| Murmur | □YES | □ NO | Parkinsons Disease | □YES | □ NO |
| Irregular heart beat | □YES | □ NO | Alzheimers | □YES | □ NO |
| High blood pressure | □YES | □ NO | Balance Problems | □YES | □ NO |
| High cholesterol | □YES | □ NO | | | |
| Valve problem | □YES | □ NO | **Psychiatric** | | |

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| | | | | | |
|---|---|---|---|---|---|
| **Respiratory** | | | Depression | □YES | □ NO |
| Asthma | □YES | □ NO | Anxiety | □YES | □ NO |
| Bronchitis | □YES | □ NO | **Endocrine** | | |
| Emphysema | □YES | □ NO | Diabetes | □YES | □ NO |
| Sleep Apnea | □YES | □ NO | Thyroid | □YES | □ NO |
| **Gastrointestinal** | | | **Blood** | | |
| GERD | □YES | □ NO | Blood Clots | □YES | □ NO |
| Diverticulitis | □YES | □ NO | Anemia | □YES | □ NO |
| Hernia | □YES | □ NO | | | |
| Hepatitis | □YES | □ NO | **Cancer** | □YES | □ NO |
| | | | Type_____ | | |

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**PHYSICAL EXAM**

**Gait:** □ Trendelenburg □ Antalgic □Other_____
**Leg Length:** □ None □ Amount _____
**Pulses:** **R** □ 2+ □ 1+ □ Doppler □ Absent **L** □ 2+ □ 1+ □ Doppler □ Absent
**Sensation:** **R** □ SILT □ Deficits_____ L □ SILT □ Deficits_____
**Motor** **R** □ EHL/FHL/TA/GAS Intact □ Deficits _____ **L** □ EHL/FHL/TA/GAS Intact □ Deficits _____

**RLE SLR** □ pain in groin □ pain down leg □ Pain in back
**LLE SLR** □ pain in groin □ pain down leg □ Pain in

**Right Hip:** Contracture: □ YES □ NO IR:____ ER_____ABD_____ADD_____

TTP over GT: □ YES □ NO

Skin incision: □ YES □ NO Description_____

**Right Knee**: Effusion**:** □ None □ Small □ Moderate □ Large

Flexion ____ Extension_____ LAG □No □ Yes _____

TTP : □ Medial joint line □ Lateral Joint Line □ Patella □ Pes □ Gerdy's □ Saph nerve

Alignment: □ Normal valgus □ Neutral □ Valgus □ Varus
Degrees Valgus/ Varus_____
Correctable □ No □ Partial □ Fully

Instability : □ Yes □ No Describe: □ V/V □ A/P □ Flexion □ Rotation

Skin incision: □ YES □ NO Description_____

**Left Hip:** Contracture: □ YES □ NO IR:____ ER_____ABD_____ADD_____

TTP over GT: □ YES □ NO

Skin incision: □ YES □ NO Description_____

**Left Knee**: Effusion**:** □ None □ Small □ Moderate □ Large

Flexion _____ Extension_____ LAG □No □ Yes _____

TTP : □ Medial joint line □ Lateral Joint Line □ Patella □ Pes □ Gerdy's □ Saph nerve

Alignment: □ Normal valgus □ Neutral □ Valgus □ Varus
Degrees Valgus/ Varus_____
Correctable □ No □ Partial □ Fully

Instability : □ Yes □ No Describe: □ V/V □ A/P □ Flexion □ Rotation

Skin incision: □ YES □ NO Description_____

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