KNEE HISTORY

NAME:_____DOB: _____ DATE:_____
Please print: First name, middle initial, last name

How old are you? _____ What is your occupation? _____ Height _____ Weight _____

Where do you live (City, State)? _____

Who may we thank for your referral to our office? _____ Physician or Patient (circle one)

With which knee are you experiencing difficulty? ____Right ____Left ____Both, If both which is worse _____

On what date did your symptoms begin? _____ If unknown how long have you been experiencing difficulty with your knee ? _____

What do you think may have caused your knee symptoms (spontaneous, overuse, exercis specific injury, an accident)

_____

Describe how you were injured: _____

_____

Please mark all that apply by ranking them in order of decreasing severity with one (1) as most significant symptom.

Which of the following knee symptoms are you experiencing?

____Pain ____Locking/catching ____Weakness ____Instability/slipping sensation
____Stiffness ____Grinding/popping ____Swelling Other _____

Where do you experience the majority if your knee pain?

____Inner side of the knee ____Back of the knee ____Front or "knee cap" area of knee
____Outer side of the knee ____Generalized pain throughout the knee

Please check all that apply to your knee discomfort:

____Aching ____Constant ____Burning
____Sharp ____Intermittent ____Present only with certain activities

Please mark the severity of your knee discomfort on a scale I----------I----------I
1 Minimal 5 Moderate 10 severe

Do you experience discomfort with any of the following activities or motions?

____Bending the knee ____Squatting or bending down ____Sitting for a prolonged period of time
____Straightening the knee ____Driving ____Going up stairs ____Going down stairs

Does knee problem interfere with any of the following?

____ Daily Activities ____ School Activities ____Work Activities ____Recreation or Sports ____Sleeping

Has your knee been evaluated by: ____Primary Care Physician ____Another Orthopedic Surgeon ____E.R. Visit

Have you had any of the following imaging studies for your knee? Please include dates, if known.

____X-ray date: _____ MRI date: _____ ____Other: _____

Please check any treatments that you tried for your knee condition?

____Rest Did it help ____Yes____No ____Ice Application Did it help ____Yes____No
____Anti-inflammatory Did it help ____Yes____No ____Cortisone injection Did it help ____Yes____No
____Physical therapy Did it help ____Yes____No ____Other _____ _____

How is your knee progressing? ____Getting better ____Staying the same __ __Getting worse

Have you ever had any significant knee injuries or require knee surgery in the past? ____Yes____No
If Yes, please explain and list prior dates, physicians, and any procedures: _____

_____

_____

Boulder Centre for Orthopedics & Spine
Your Life in Motion

PHYSICAL EXAM: TO BE COMPLETED BY PROVIDER

PHYSICIAN/PA EXAMINATION (for physician only) R L B

____A&O x 4, appropriate, ambulates normally. ____Skin no lesions/signs infection/incisions healed/sutures

R L B TTP at patella___ patellar tendon___ quad tendon___ MJL___ LJL___ fibula___ R L BLE NVI saph/sural/sp/dp/tib

Effusion_____ Ballotable_____

R L B Knee AROM/PROM Flexion-Extension _____Recurvatum_____Crepitus_____

R L B Knee Stability: Ant Drawer _____ Post Drawer ____ Varus @0 _____ @30_____ Valgus @0_____ @30 _____

Lachman _____Pivot Shift _____ Patellar stability_____ Patellar app _____ J sign _____

R/L/B Strength testing (out of 5) Flex____ Ext____ Hip Flex _____ Hip Ext _____

SPECIAL: McMurray__ med____lat_____ Thessaly_____ Patellar compression: _____

VASCULAR: _____ DP & PT pulse ____ CR WNL

PMH: □ Reviewed Intake Form □ DVT/PE Negative □ DVT/PE Positive

MEDS:_____

ALLERGIES: □ NKDA □ Positive:

PSH: _____

SH: □ Married □ Partnered □ Single

Occupation:_____ □ Retired □ Disabled

Tobacco: ETOH: THC/drugs: Activities/Hobbies: _____

_____

XRAY: _____

MRI: _____

Assessment: _____

Plan: _____

F/U_____