

DATE: _____

Patient DOB _____

Southside Orthopaedics P.C.

PATIENT QUESTIONNAIRE INITIAL KNEE EVALUATION

Patient Name: _____ Family/Referring Doctor: _____

Doctor's Address: _____

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. Circle the word or phrase that best describes your situation. You may select more than one answer per question. Answer in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. THANK YOU.

Age: _____ Sex: M / F Dominant Hand: R / L Marital status: S M D W

Occupation/Grade: _____ Place of Work/School: _____

Who referred you to Southside Orthopaedics P.C. ? _____

Which knee is injured? R / L When did the problem first start or when did the injury occur? _____

Have you seen a doctor in the past for this problem/injury? NO / YES

If yes, who and when? _____

Explain in your own words how this injury occurred. _____

What treatment have you had ? _____

Have you had previous surgery? NO / YES, If yes what kind: _____

Did this injury occur as a result of: Normal daily activity Other: _____
Motor vehicle accident
Contact sport
Non-contact sport
Work

Prior to this injury were you involved in: Strenuous activities Since your injury? Strenuous activities
Moderate activities Moderate activities
Light activities Light activities
Sedentary activities Sedentary activities

How does you knee function today? Normal Nearly normal Abnormal Severely Abnormal

At which of the following levels will you experience significant symptoms?

	Strenuous activity	Moderate activity	Light activity	Sedentary activity
Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swelling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Partial giving way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Full giving way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Locking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY

Are you allergic to any medications? NO / YES (Circle all that apply.)

- (A) Penicillin
- (B) Codeine
- (C) Sulfa
- (D) Iodine/Betadine
- (E) OTHER: _____

Do you currently have any medical problems? NO / YES (Circle all that apply.)

- (A) Hypertension
- (B) Liver disease
- (C) Coronary artery disease
- (D) Seizure Disorder
- (E) Peripheral vascular disease
- (F) Thyroid disease
- (G) Adult onset diabetes
- (H) Emphysema
- (I) Childhood onset diabetes
- (J) COPD/Lung problem
- (K) Past heart attack
- (L) Immune Disorder
- (M) Asthma
- (N) Overweight
- (O) Ulcers
- (P) Osteomyelitis
- (Q) Hepatitis
- (R) Tuberculosis
- (S) Cancer
- (T) OTHER: _____

Do you take ANY medications? Please include both prescription and non-prescription drugs.

Medication	Dose	Times a day

Have you ever had previous surgery? NO / YES

- (A) Appendectomy
- (B) Lumbar laminectomy
- (C) Cataract extraction
- (D) Mastectomy
- (E) By-pass/open heart
- (F) Tonsillectomy
- (G) Gall bladder
- (H) Prostate surgery
- (I) Hernia repair
- (J) Hysterectomy
- (K) OTHER (specify) _____

Any broken bones? NO / YES _____

Have you ever received a blood transfusion? NO / YES _____

Has anyone in your immediate family ever had any of the following? NO / YES (Circle any that apply)

- (A) Cancer
- (B) Colitis
- (C) Leukemia
- (D) Bleeding tendency
- (E) Stroke
- (F) Asthma
- (G) Hypertension
- (H) Tuberculosis
- (I) Coronary Artery disease
- (J) Seizure disorder
- (K) Rheumatic fever
- (L) Alcoholism
- (M) Diabetes
- (N) Hypothyroidism

How much alcohol do you consume?

- (A) I am a nondrinker.
- (B) I am a recovering alcoholic.
- (C) I drink only occasionally.
- (E) An average of 1-2 drinks per day/week/month
- (F) An average 2-3 drinks per day/week/month
- (G) An average 3 -4 drinks per day/week/month

Do you now, or have you ever, smoked cigarettes?

- (A) Yes, I am currently a smoker.
I smoke (circle one) 1 2 3 4 packs/day.
I have smoked for _____ years.
- (B) No, but I used to smoke. I smoked for _____ years.
- (C) No I have never smoked.

Do you now, or have you ever, used recreational drugs? NO / YES _____

REVIEW OF SYSTEMS: Tell us about your health in general -- Do you have any of the following?

SYMPTOMS			COMMENTS
Chest pain	YES	NO	_____
Dizziness	YES	NO	_____
Dry cough	YES	NO	_____
Productive cough	YES	NO	_____
Difficulty breathing	YES	NO	_____
Irregular heartbeat	YES	NO	_____
Swelling in legs	YES	NO	_____
Loss of appetite	YES	NO	_____
Increase in appetite	YES	NO	_____
Nausea	YES	NO	_____
Vomiting	YES	NO	_____
Diarrhea	YES	NO	_____
Constipation	YES	NO	_____
Blood in your stool	YES	NO	_____
Abdominal cramping	YES	NO	_____
Varicose veins	YES	NO	_____
Bruising	YES	NO	_____
Bleeding	YES	NO	_____
Nose bleeds	YES	NO	_____
Joint pain and/or stiffness	YES	NO	_____
Muscle pain or muscle cramps	YES	NO	_____
Difficulty seeing	YES	NO	_____
Difficulty hearing	YES	NO	_____
Difficulty swallowing	YES	NO	_____
Difficulty sleeping	YES	NO	_____

Thank you for completing this patient questionnaire. It will become a part of your permanent record.

Patient/Guardian Signature: _____ Date: _____

Reviewed By: _____ Date: _____