

LOWER EXTREMITY EVALUATION / NORTHWEST OKLAHOMA ORTHOPAEDIC CLINIC

GENERAL INFORMATION

Name: _____ Birthdate: _____ Visit Date: _____

Which Hip Left Right Both Neither
 Which Knee Left Right Both Neither
 Onset of pain Sudden Gradual

Any prior knee injury <input type="checkbox"/> Yes <input type="checkbox"/> No	Any prior hip surgery <input type="checkbox"/> Yes <input type="checkbox"/> No
Back pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Any Locking Sensations <input type="checkbox"/> Yes <input type="checkbox"/> No
Any Catching <input type="checkbox"/> Yes <input type="checkbox"/> No	Any Giving Way Sensations <input type="checkbox"/> Yes <input type="checkbox"/> No
Any painful popping <input type="checkbox"/> Yes <input type="checkbox"/> No	Any Popping that relieves pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Any pain arising after extended rest <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain with twisting motions <input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain with stairs or ramps <input type="checkbox"/> Yes <input type="checkbox"/> No
Pain awakens from sleep <input type="checkbox"/> Yes <input type="checkbox"/> No	Groin pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Buttock pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Any back problems, surgery, sciatica <input type="checkbox"/> Yes <input type="checkbox"/> No

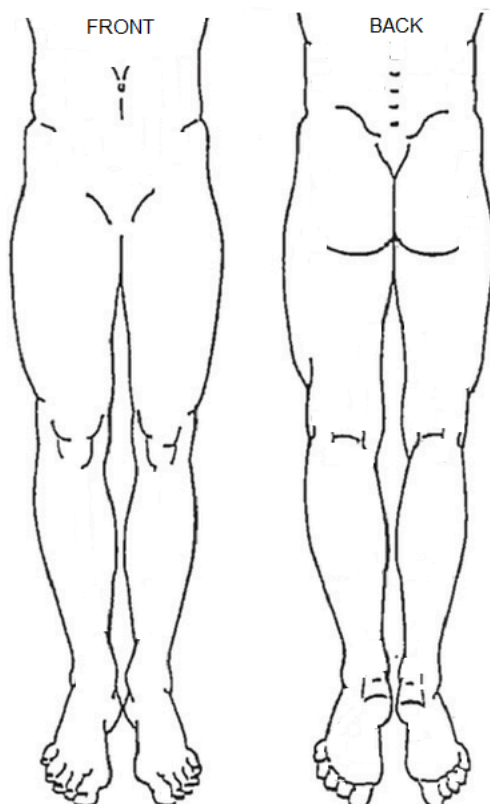
0 = No pain / 1 = Mild, aware but not bothersome / 2 = Moderate, tolerate without medication / 3 = Moderate, requires medication
 4-5 = More severe, begin to feel antisocial / 6 = Severe / 7-9 = Intensely severe / 10 = Most severe, may make you contemplate suicide

Circle your pain level using the guide below: **0 1 2 3 4 5 6 7 8 9 10**

TREATMENTS / MEDICATIONS / RADIOGRAPHIC STUDIES

Note: CMS requirements for joint replacement in most circumstances require at least 4 weeks attempt at pain control with medications, if tolerated, and at least 12 weeks of either physical therapy or an ambulatory assistive device or aid to relieve pain. Other insurance requirements vary.

Any **Physical Therapy** Yes No If YES, approximately how many visits, when, where:
 Any **Injections** Yes No If YES, when and by whom and what was injected:
 Any **Medications** for pain Yes No If YES, list medications and how often and how long used:
 Any **Surgeries** Yes No If YES, when and by whom and what surgery:
 Any **X-RAY / MRI / CT** done Yes No If YES, when, where, by whom:
 Do you utilize a Cane / Walker / Brace / Shoe inserts / any Ambulatory Assistive Device Yes No If so, how long

SYMPTOMS	FRONT BACK	KEY
Circle all symptoms that may apply to you: Throbbing / Shooting / Boring / Stabbing / Sharp / Pinching / Pressure / Gnawing / Cramping / Tugging / Pulling / Hot / Burning / Scalding / Searing / Tingling / Dull / Sore / Aching / Heavy / Agonizing / Tiring / Annoying / Miserable / Intense / Unbearable / Spreading / Radiating / Piercing / Tight / Numb / Tearing / Cold / Freezing / Nagging <hr/> IMPORTANT: Have you had any history of lumbar spine or back problems or surgeries. If so, use this space to describe or write "none" below.		<p>Show by filling in, marking and drawing on the front and back figures to the right where you are having any of the below symptoms:</p> <p>Aching &/or Pain XXXXX</p> <p>Numbness &/or Tingling OOOOO</p> <p>Pins &/or Needles</p> <p>Burning /////</p> <p>Spasms &/or Cramps △△△△△</p>