HIP & KNEE 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	☐ Yes	☐ No	Any prior hip surgery	☐ Yes	☐ No
Back pain	☐ Yes	☐ No	Any Locking Sensations	☐ Yes	☐ No
Any Catching	☐ Yes	☐ No	Any Giving Way Sensations	☐ Yes	☐ No
Any painful popping	☐ Yes	☐ No	Any Popping that relieves pain	☐ Yes	☐ No
Any pain arising after extended rest	☐ Yes	☐ No	Pain with twisting motions	☐ Yes	☐ No
Swelling	☐ Yes	☐ No	Pain with stairs or ramps	☐ Yes	☐ No
Pain awakens from sleep	☐ Yes	☐ No	Groin pain	☐ Yes	☐ No
Buttock pain	☐ Yes	☐ No	Any **back** problems, surgery, sciatica	☐ Yes	☐ No

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

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

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:

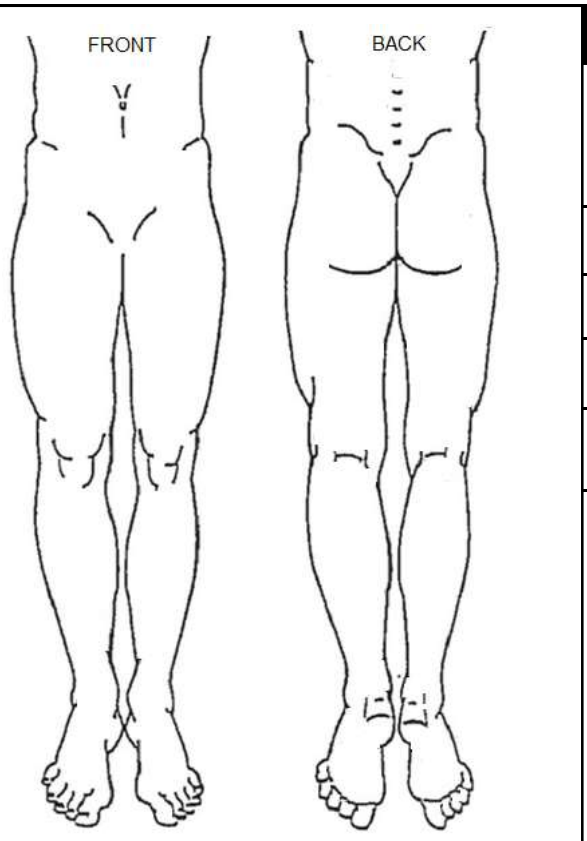
Do you utilize a Cane / Walker / Brace / Shoe inserts / any Ambulatory Assistive Device ☐ Yes ☐ No If so, how long

SYMPTOMS

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

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.



KEY

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:

Aching &/or Pain	XXXX
Numbness &/or Tingling	ooooo
Pins &/or Needles	.....
Burning	//////
Spasms &/or Cramps	ΔΔΔΔΔ

Signature _____ Date _____ Rev. 05/23/2018 ©