Orthopaedic Associates of Zanesville
2854 Bell Street Zanesville, Ohio 43701 P: 740-454-3273 F: 740-588-1081 www.orthozane.com

KNEE HISTORY

Patient Name:_____DOB:_____Date:_____

CHIEF COMPLAINT (Briefly, what brings you here):

_____

_____

Is today's condition a result of an accident? Yes _____ No _____
If "yes", please circle: auto accident work accident other

Is today's condition the result of an injury? Yes_____ No_____
If "yes": How, When and Where did the injury occur? _____

_____

HISTORY OF PRESENT ILLNESS:

- Which Knee? **Right or Left**
- Where is your pain located:

  _____
- Describe your symptoms/pain (e.g.constant/intermittent pain, sharp/dull, frequency)

  _____

  _____
- How severe is it? (1-10 scale) _____ How long have you had it? _____
- What aggravates the pain? (please circle all that apply):
  - Stairs
  - Twisting/Pivoting
  - Biking
  - Stooping/Squatting
  - Jumping
  - Running
  - Other:_____

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KNEE HISTORY (cont'd)

- Does the pain radiate? Yes or No
- Does the pain limit your daily activities? Yes or No
  If yes, describe how?_____
- How far can you walk before having knee pain? (circle one)
  1 step 10 feet city block no limit
- Is the knee stiff? (Have you lost motion) Yes or No
- Do you have night pain? Yes or No
- Any "mechanical" symptoms? (please circle all that apply):
  Locking Popping Catching Giving way
- Do you work out with weights? Yes or No
- Any swelling? Yes or No
- Any history of trauma?
  If yes, when and how? _____
- Any previous knee surgery?
- If yes, when and type? _____
- Prior injections? (Cortisone, "Gel" or Visco) Yes or No
- Any pain in the hip or groin? Yes or No
- Do any of the following decrease your pain?
  - Rest: Yes Minimally No
  - Ice: Yes Minimally No
  - Heat: Yes Minimally No
  - Over the counter meds(ie Aleve) Yes Minimally No
  - Prescription meds: Yes Minimally No
  - Physical therapy Yes Minimally No
    When tried?_____ How Long? _____
  - Home exercises or conditioning? Yes Minimally No
    When tried?_____ How Long?_____
- Is there anything else that decreases your pain? _____
- Any previous X-rays or MRI's? Yes or No
- Have you seen any other doctor for this problem? Yes or No
  If "yes" who and when? _____
- Have you ever had a problem with this knee before (or on the other side)? If yes, explain_____
- Have you fallen due to a knee condition? Yes or No

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KNEE HISTORY (cont'd)

- Describe your usual daily activity/work activity: (please circle all that apply)
  - o Sedentary
  - o Walking
  - o Active
  - o Standing
  - o Lifting
  - o Climbing
  - o Other:_____ _____
- What is your job description? _____
- Do you have a good appetite? Yes or No
- Have you had any weight loss or tried to lose weight? Yes or No

CURRENT MEDICATIONS (include non-prescription meds and herbal supplements, etc.)
*****Supply a list of current medications, with the name, dose and how the medication/supplement is taken.*****

ALLERGIES:

Medications None _____ Yes _____
(*Please describe the medication and the allergic reaction*)
_____
Latex None _____ Yes _____
Metal None _____ Yes _____