ROPER ST. FRANCIS
PHYSICIAN PARTNERS

Orthopaedic Surgery & Sports Medicine

New Patient Intake- Hip & Knee

Patient Name: _____
DOB: _____ Age: _____ Referred by: _____
PCP: _____

Reason for Today's Visit:

☐ Right hip ☐ Left hip ☐ Right Knee ☐ Left Knee ☐ Bilateral Hips ☐ Bilateral Knees ☐ Other _____

Please describe, what you hope to achieve or take away from today's appointment: _____

_____

Check one of the following:

☐ No Injury- estimated date symptoms began: _____

☐ Injury- date of injury: _____

If injury:

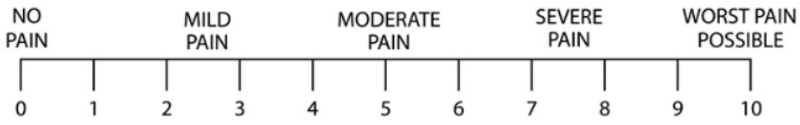
Where did the injury occur? (Circle One) Home Work School Other_____

Is this a sports related injury? ☐ YES ☐ NO Sport: _____

Did you hear a "pop" when you injured your knee? ☐ Yes ☐ No

Did you experience immediate swelling? ☐ Yes ☐ No

Rate your pain on a scale of 1 to 10. (Circle Number)



Check all exacerbating factors that apply.

Climbing Stairs__	Housework__	Exercise__
Bending__	Kneeling__	Squatting__
Running__	Walking__	Sitting__
Jumping__	Laying Down__	Sudden Movements__
Donning Socks/Shoes__		

Other: _____

When does it bother you the most? _____

Do you have pain at night? ☐ YES ☐ NO

Does this pain cause falls or make you nervous about falling? ☐ YES ☐ NO

Check all symptoms that apply.

Numbness__	Tingling__	Stiffness__	Locking__
Swelling__	Throbbing__	Instability__	Catching__
Weakness__	Popping__	Aching__	Constant__
Sharp pains__	Shooting Pains__	Stabbing Pains__	Dull Pain__

Other: _____

Previous Treatment:

Have you had any recent imaging? ☐ YES ☐ NO
If yes, (circle one)
Type of Imaging: X Ray MRI CT
Date Performed: _____ Facility: _____

Have you had any previous surgical procedures to this body part for this problem? ☐ YES ☐ NO
If yes, Procedure: _____ Date: _____ Provider: _____

What treatments have you tried, if any? (Check all that apply)
Cortisone Injections__ Physical Therapy__ Warm Compresses__ Icing__ Cane__
Visco-Supplement Injections__ Voltaren Gel__ Orthotics__ Weight loss__ Crutch__

Have you tried any over the counter medications? (Check all that apply)
Aleve__ Advil__ Aspirin__
Tylenol__ Ibuprofen__
How often do you take these medications? _____

Have you experienced complications with any type of anesthesia? (Check all that apply or fill in the blank)
General__ IV Sedation__ Local anesthesia__
Dental anesthesia__ Other: _____

Medical/Social History:

Do you have any blood relatives with osteoporosis or arthritis? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO Do you drink? ☐ YES ☐ NO
If yes, how many packs a day_____ If yes, how much in a week _____

Are you pregnant? ☐ YES ☐ NO

Allergies: Please list any additional allergies below.

Medication Name	Date Noted/Reaction

Medications: Please list any medications you are currently taking including over-the-counter medication.

Medication Name	Dosage