THE SPORTS MEDICINE CENTER AT

DANBURY ORTHOPEDICS

Exceptional Care. Real Results.

DR. BRAND
KNEE MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Date: _____

Orthopedic History: _____ Reason for Visit: _____

Is this problem a result of: ❑ MVA ❑ Liability ❑ Work Related ❑ Trauma

Date of Injury: ____/____/____ Description of Injury: _____

Side: ❑ Right ❑ Left Dominant: ❑ Right-Handed ❑ Left-Handed

History of Present Injury or Complaint: _____

How long have you had knee pain? _____

Did you have an injury? (explain) _____

Does your knee feel unstable (feeling like it may give way on you)? ❑ Yes ❑ No

Does your knee lock? ❑ Yes ❑ No

Does your knee hurt when you go up and down stairs? ❑ Yes ❑ No

Does your knee hurt when you squat down? ❑ Yes ❑ No

Does your knee swell? ❑ Yes ❑ No

What sports or activities do you participate in? _____

Are you taking any medications for your knee? _____

Do you now have or have you ever had:

CONSTITUTIONAL:

Recent weight changes	❑ Yes	❑ No				
Recent fever, weakness or fatigue	❑ Yes	❑ No				

EYES:

Wear glasses or contact lenses	❑ Yes	❑ No				
Glaucoma	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Cataracts	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:

EARS, NOSE, THROAT:

Hearing problems	❑ Yes	❑ No				
Dizziness	❑ Yes	❑ No				
Recent cold or sinus pain	❑ Yes	❑ No				
Recent sore throat	❑ Yes	❑ No				

CARDIOVASCULAR:

Chest pain	❑ Yes	❑ No				
Heart attack	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Stroke	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Heart failure	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
High blood presure	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Irregular heartbeat	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Swelling of hands or feet	❑ Yes	❑ No				
Blood clots	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
High cholesterol	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:

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RESPIRATORY:

Asthma ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

Emphysema ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

Bronchitis ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

Pneumonia ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

GASTROINTESTINAL:

Recent changes in bowel habits ❑ Yes ❑ No

Rectal bleeding ❑ Yes ❑ No

Liver disease ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

URINARY:

Problems with urination ❑ Yes ❑ No

Urinary tract infections ❑ Yes ❑ No

Kidney disease ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

SKIN:

Recent or current rashes or eruptions ❑ Yes ❑ No Where: _____

NEUROLOGICAL:

Seizures ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

Paralysis ❑ Yes ❑ No Where: _____

Numbness or tingling ❑ Yes ❑ No Where: _____

Depression/mental illness ❑ Yes ❑ No When: _____

Anxiety disorders ❑ Yes ❑ No When: _____

ENDOCRINE:

Thyroid ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

Diabetes ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

Treatment: ❑ Diet ❑ Oral Meds ❑ Insulin

Medical Complications: ❑ Vascular ❑ Renal ❑ Neuropathy ❑ Other: _____

HEMATOLOGIC/LYMPHATIC:

Anemia ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

Transfusions ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

CANCER/TUMOR: ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

Type: _____ Location: _____ Treatment: _____

OTHER MEDICAL PROBLEMS: _____

_____

_____

HISTORY OF OPERATIONS: ❑ Yes ❑ No

Type: _____

_____

_____

DO YOU HAVE ALLERGIES, SENSITIVITIES OR HAVE YOU AN ADVERSE REACTION TO MEDICATIONS? ❑ Yes ❑ No

Please List: _____

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CURRENT MEDICATIONS: _____

When did you last use aspirin in any form? _____

PERSONAL HISTORY:

Cigarettes ❑ Yes ❑ No Amount: _____

Alcohol ❑ Yes ❑ No Amount: _____

OCCUPATION: _____

TESTS DONE RELATED TO PRESENT INJURY OR COMPLAINT:

❑ X-rays ❑ MRI ❑ CT Scan ❑ EMG ❑ Bone Scan ❑ Bone Density ❑ Bloodwork

Tests performed at: _____

PRIOR TREATMENT (Best recollection – Check and explain):

❑ Anti-Inflammatories:

❑ Injections (dates & number):

❑ Chiropractic:

❑ Surgery:

Physical Therapy: ❑ Ulttrasound ❑ Massage ❑ Strengthening ❑ ROM Stretching
❑ Cybex Machines ❑ Cryotherapy ❑ Cortisone Cream ❑ Manipulation
❑ Electrical Stimulation

YOUR MEDICAL DOCTOR: Name: _____

Address: _____

Phone: _____

YOUR REFERRING DOCTOR: Name: _____

Address: _____

Phone: _____

PATIENT SIGNATURE: _____

MD SIGNATURE/DATE: _____

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TO BE FILLED OUT BY THE PHYSICIAN

GENERAL APPEARANCE ❑ Contusion/Abrasion ❑ Scars

GAIT

LUMBAR SPINE

HIP EXAM

ANKLE

KNEE Alignment ❑ Varus ❑ Valgus

ROM

EFFUSION ❑ None ❑ 1+ ❑ 2+ ❑ 3+ ❑ 4+

PATELLOFEMERAL JOINT ❑ Crepitus ❑ Q Angle ❑ Retinacular tenderness ❑ Apprehension

JOINT LINE TENDERNESS ❑ Medial ❑ ateral

MENISCUS STRESS TEST

LIGAMENTS
❑ Lachman
❑ Pivot shift sign
❑ Varus/Valgus ❑ 0 ❑ 30
❑ Posterior
❑ Posterior lateral

STRENGTH
❑ Quads
❑ Hams

POPLITEAL CYST

NEUROVASCULAR ❑ Pulses ❑ DP ❑ POP