

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 pressure 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: _____

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 Where: _____

Anxiety disorders Yes No Where: _____

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: _____

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: Ultrasound 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: _____

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 Lateral

MENISCUS STRESS TEST

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

STRENGTH Quads
 Hams

POPLITEAL CYST

NEUROVASCULAR Pulses DP
 POP