

	Use Patient Plate
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Primary Care Physician Name & Address

Referring Physician Name & Address (if different from primary care physician)

Today's Date

Standard Patient Questionnaire
 All information in this questionnaire will be included in your medical record and will be held strictly confidential.

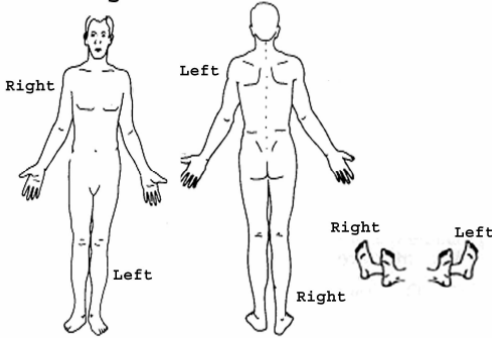
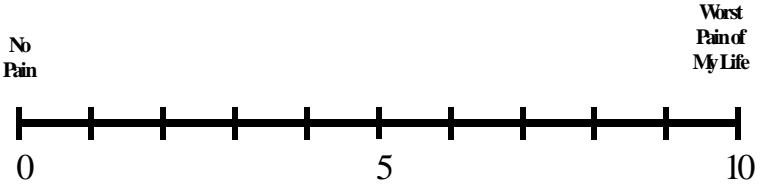
Name: (Last, First, M.I.)	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth
		Age

History of Present Illness

What part of your body is driving you to seek medical attention?
 HIP KNEE OTHER

Which side?	If you have an injury to the affected part, when did it occur?
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How did the injury or accident happen?

<p>Pain Diagram</p> 	
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What makes your pain better? (rest, ice, heat, massage, medications)	
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What makes your pain worse? (activity, walking, running, bending, squatting)	
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What is the quality of your pain (sharp, dull ache, burning, other)	
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How many hours a day do you have this pain?		
Do you have pain at rest?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the pain radiate to anywhere else? If yes, where?		
Do you have any of the following?		
swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	popping or clicking <input type="checkbox"/> Yes <input type="checkbox"/> No
numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	giving way <input type="checkbox"/> Yes <input type="checkbox"/> No
What limitations of your daily routine do you have due to this injury?		
Have you injured this area prior to this injury? If so, explain.		
Do you use any walking aids		<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, what do you use?	<input type="checkbox"/> Cane	<input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Wheelchair
What percent of the time do you use walking aids?		%
Do you use any braces?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use any orthotics in your shoes? If yes, please explain:		<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
How far can you walk?		<input type="checkbox"/> Miles <input type="checkbox"/> Yards <input type="checkbox"/> Blocks
What treatments have you had for your current condition?		
Cortisone injections? If yes, when and how often?		<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
Viscosupplementation? (Synvisc, Hyalgan) If yes, when and how often?		<input type="checkbox"/> Yes <input type="checkbox"/> No Explain
Do you take any antiinflammatory medications?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take Chondroitin Sulfate and Glucosamine?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty with stairs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have more difficulty going up or down stairs?		<input type="checkbox"/> Up <input type="checkbox"/> Down
Do you put both feet on each step?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use a rail when going up and down steps?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Can you put on your shoes and socks?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Can you cut your toenails yourself?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list any known medical conditions or problems.		Year of onset

Please list surgeries that you have undergone.	Year performed

Please list any over the counter or prescribed medications.		
Drug Name	Strength or Dose	Taken when and how often?
Medication Allergies: <input type="checkbox"/> No Known Allergies OR	1. 2. 3.	

FAMILY HISTORY: Please list any illnesses of family members or cause of death if known.

	Age	Mark X if Alive and Well	Mark X if deceased	Describe family member illness or cause of death if known
Mother				
Father				
Sisters				
Brothers				
Children				

Review of Systems: Check if you have had, or currently have any of the following symptoms and the date of onset

	Symptom	Date of Onset
<input type="checkbox"/>	Fevers	
<input type="checkbox"/>	Chills	
<input type="checkbox"/>	Night Sweats	
<input type="checkbox"/>	Rashes/Frequent Itching	
<input type="checkbox"/>	Sores that don't heal	
<input type="checkbox"/>	Hearing Loss	
<input type="checkbox"/>	Nasal Problems	
<input type="checkbox"/>	Difficulty Swallowing	
<input type="checkbox"/>	Thyroid Problems	
<input type="checkbox"/>	Weight Loss	
<input type="checkbox"/>	Weight Gain	
<input type="checkbox"/>	Excessive sweating	
<input type="checkbox"/>	Tremor	
<input type="checkbox"/>	Chest Pain	
<input type="checkbox"/>	Shortness of Breath	
<input type="checkbox"/>	Cough	
<input type="checkbox"/>	Enlarged Heart	
<input type="checkbox"/>	Irregular Heart Beat	
<input type="checkbox"/>	Heart Murmur	
<input type="checkbox"/>	Wheezing	
<input type="checkbox"/>	Vein Problems	
<input type="checkbox"/>	Others:	

	Symptom	Date of Onset
<input type="checkbox"/>	Phlebitis	
<input type="checkbox"/>	AIDS	
<input type="checkbox"/>	Hepatitis B	
<input type="checkbox"/>	Hepatitis C	
<input type="checkbox"/>	Previous Deep Vein	
<input type="checkbox"/>	Transient Ischemic	
<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	Calf Pain on Exertion	
<input type="checkbox"/>	Easy Bruisability	
<input type="checkbox"/>	Swollen Nodes	
<input type="checkbox"/>	Paralysis	
<input type="checkbox"/>	Weakness	
<input type="checkbox"/>	Numbness	
<input type="checkbox"/>	Tingling in Arms or	
<input type="checkbox"/>	Painful Urination	
<input type="checkbox"/>	Frequent Urination	
<input type="checkbox"/>	Bloody Urine	
<input type="checkbox"/>	Bleeding Ulcers	
<input type="checkbox"/>	Hiatal Hernia	
<input type="checkbox"/>	Frequent Indigestion	
<input type="checkbox"/>	Colitis	

Social and Activity History: This information may impact your health insurance. If you have any concerns about this please leave the information blank and discuss it verbally with your physician to ensure confidentiality.

Smoking (Tobacco)	How many per day?	How many years?
Cigarettes <input type="checkbox"/> Yes <input type="checkbox"/> No		
Cigars <input type="checkbox"/> Yes <input type="checkbox"/> No		
Pipe <input type="checkbox"/> Yes <input type="checkbox"/> No		
Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No		
Illicit Drugs	Are you currently using or have you used any illicit drugs such as methamphetamine or cocaine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever used intravenously injected drugs such as heroin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Highest Grade of School Completed	<input type="checkbox"/> Elementary <input type="checkbox"/> HighSchool <input type="checkbox"/> College <input type="checkbox"/> Post-Graduate	

Current Occupation									
Marital Status		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other							
Hobbies/Activities/Sports		How many hours a week do you perform these activities?							
Physical Examination (To be filled out by MD)									
General		Standing Alignment <input type="checkbox"/> Varus <input type="checkbox"/> Valgus Deg							
App		Gait <input type="checkbox"/> Trend <input type="checkbox"/> Antalgic Side							
Hip				Knee					
TTP	<input type="checkbox"/> Yes <input type="checkbox"/> No Location			Effusion		Standing Alignment			
ROM (Extension)				TTP					
Flexion	Extension		ABD		Medial		Lateral		
ADD		ER		IR		Stability			
ROM (90 Flexion)				Varus		Valgus			
Flexion		Extension		ABD		Lachman		Post Drawer	
ADD		ER		IR		Patellofemoral Joint			
Anterior Apprehension			Posterior Apprehension			Crepitance		Apprehension	
LLD	<input type="checkbox"/> EqL	<input type="checkbox"/> R>L	<input type="checkbox"/> L>R	cm?		Flexion		Extension	
Vascular DP				PT					
Sensory			DTR		KJR R L		AJR R L		
Motor Q		JS		TA		GS		EHL FHL	