GIKK ORTHO SPECIALISTS

TODAY'S DATE:_____

PATIENT NAME: _____DATE OF BIRTH: _____ AGE: _____

Height:_____, Weight_____

HOME PHONE #: _____ CELL PHONE #:_____

1). Please explain what your problem is and what your goals and expectations are:

_____

_____

2). Are you interested in a surgical procedure or non-surgical procedure?

_____

_____

3). If you are here for knee pain check where you have pain:

___medial (big toe side), ___lateral (little toe side), ___anterior compartment (knee cap), _____generalized.

4). If you are here for hip pain check where you have pain: ___groin,___ outer hip area,

___buttock ,___anterior thigh, ___ knee ,___ anterior leg

5). How long have you had pain? _____

6). How many blocks can you walk comfortably?

___Less than 1 block, ___1-2 blocks, ___3-6 blocks, _____Over 6 blocks

7). Please mark the activities that bother you: ___walking, ___getting out of a chair,

_____doing stairs,___trouble sleeping,___trouble getting dressed

8). Do you have: ___swelling, ___stiffness, ___joint locks, __giving out, _____don't trust your extremity to hold you

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9). Do you use a cane? _____ , Do you use a walker? _____

10). Are you on any blood thinners? Such as: Plavix, Coumadin, Xarelto, Pradaxa, Pletal, Aggrenox, eliquis

11). Are you on any rheumatoid drugs? Such as: Methotrexate, Humira, Remicade, or Enbrel.

12). What do you take for pain? _____

13). If you have cortisone when was your last injection in your knee_____, or hip?_____

14). If you have had viscosuppementation ("chicken shots") when was your last shot____

15). List any surgery on your hip or knee. Date of surgery and where surgery was performed. _____

GENERAL MEDICAL QUESTIONS

1). Have you seen your dentist in the last six months? YES - NO

2). Circle any of the following risk factors you might have for your heart:

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Angina – requiring taking nitroglycerin	**Vascular Disease – such as stroke**
Heart Attack	**Hypertension**
Diabetes	**High Cholesterol**
Smoking	**Positive Family History of Heart Attack (mother, father, or siblings)**
Obesity	**Sedentary Activity (Walking less than 1-2 blocks at a time)**

3). Do you have a history of a cardiac bypass, coronary angioplasty? _____

4). Do you have a history of a pulmonary embolism, (blood clot in your lung), DVT (phlebitis in your leg)_____

5). Have you ever had a bleeding ulcer? YES - NO

6). Do you have a history of sleep apnea? YES - NO

If so, mark risk factors you may have: ___Snoring, ___obesity, ___ hypertension, ___excessive tiredness during the day, _____getting up at night, _____ observed apneas (snore so loud you wake yourself up, or wake up gasping for air), ___congestive heart failure, _____coronary artery disease, _____atrial fibrillation, ___ 17" neck male,___16" neck female