

KNEE PATIENT FORM



PATIENTS NAME

____/____/____

DATE

Thank you in advance for completing this questionnaire. This should take approximately 30 minutes to fill out. The purpose of these questions is to provide more effective and efficient care. Health question surveys are important way to evaluate the outcomes of different treatment and therefore allow doctors to provide the highest quality of care.

The information that you provide will help us better understand your general health and specific problems related to the conditions of the bone and muscle.

This is a confidential document.

HOW DID YOU HEAR ABOUT Matthys Orthopaedic Center (M.O.C.)?

- Newspaper
- Internet
- Billboard
- Phone Book/Yellow pages
- Mailer
- Another patient
- I am already a patient of Dr. Matthys'
- Another Doctor referred me
- Other: _____

NAME OF REFERRING DOCTOR

City and State of Referring Doctor

NAME OF FAMILY DOCTOR (if different)

City and State of Family Doctor

<input type="checkbox"/> M	<input type="checkbox"/> F
AGE	
<input type="text"/>	<input type="text"/>

CURRENT EMPLOYMENT STATUS:

- Full time, secretarial or administrative type work
- Full time, with minimal lifting/bending and climbing/walking (eg. Truck driver)
- Full time, with frequent lifting/bending and climbing/walking (eg. Carpenter, Farmer)
- I am on modified duty because of today's problem
- I am on modified duty because of another unrelated problem.
- Part- Time
- Student
- Retired
- Unemployed
- Disabled. Explain cause/reason for disability:

JOB TITLE/OCCUPATION

EMPLOYER:

IS THIS IS WORKMAN'S COMP CASE?

yes no

HAVE YOU SEEN ANOTHER ORTHOPEDIC DR. FOR YOUR SYMPTOMS?

yes no

HAVE YOU CONSULTED A LAWYER ABOUT TODAY'S PROBLEM?

yes no

WHICH KNEE IS BOTHERING YOU?

- RIGHT LEFT BOTH

HOW DID THE INJURY HAPPEN (CHECK ALL THAT APPLY)

- No Specific Injury. Then go to next question please →
 Automobile Accident
 Slip and/or Fall
 Lifting Activity
 Blow or Impact Injury to the Knee
 Twisted Knee
 Jumping Activity

DATE of accident or onset of symptoms:

□ □ - □ □ - □ □

IF THERE WAS AN ACCIDENT, PLEASE DESCRIBE HOW IT HAPPENED?

IF NO SPECIFIC INJURY, HOW LONG HAVE YOU HAD THESE SYMPTOMS?

- No current symptoms 6 months to 1 year.
 Less than one week 1 year to 3 years
 Less than 2 months 3 years to 5 years
 2- 6 months greater than 5 years

PLEASE DESCRIBE YOUR CURRENT PROBLEM?

- This is a **NEW** injury. I have never had problems with the knee before.
 The symptoms **started slowly** and have progressively worsened.
 I have had this problem for **many years** and the symptoms have stayed the same
 This is a **re-injury**. Treatment was received in the past and was better until a new injury occurred.

COMPARED TO 2 MONTHS AGO, HOW WOULD YOU RATE YOUR SYMPTOMS?

- No current symptoms
 Much Better
 Little Better
 the same
 Little Worse
 Much Worse

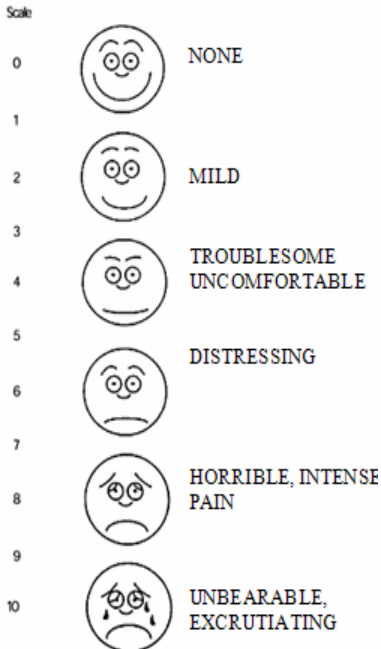
WHAT MAKES YOUR PAIN WORSE?

- WALKING
 SPORTS or RECREATIONAL ACTIVITY
 PROLONGED SITTING
 GOING UP OR DOWN AN INCLINE (Stairs)
 WALKING ON FLAT SURFACES (Floors)
 WORK
 KNEELING
 OTHER _____

WHAT MAKES YOUR PAIN BETTER?

- MY PAIN IS LESS WHEN I AM ACTIVE
 MY PAIN IS LESS IF I REST IT
 MEDICATION
 THERAPY
 INJECTIONS
 WORK
 KNEELING
 OTHER _____

HOW INTENSE IS YOUR KNEE PAIN? IF '0' IS NO PAIN AND '10' IS SEVERE PAIN? Please circle a number that applies.



WHERE IS THE PAIN? PLEASE CHECK (X) ALL THOSE THAT APPLY:

- LOWER BACK
 PAIN THAT STARTS IN THE BACK OR BUTTOCK AND RUNS DOWN THE THIGH AND INTO THE CALF OR FOOT
 BUTTOCK/"BILLFOLD" REGION
 OUTER PART OF UPPER THIGH
 GROIN
 FRONT OF THIGH
 KNEE PAIN (see diagram below)
 CALF PAIN
 FOOT PAIN

RIGHT THIGH AND LEG: PLEASE MARK THE AREA(S) BELOW

WITH AN "X" FOR **SHARP PAIN**

or an "O" FOR **NUMBNESS**.

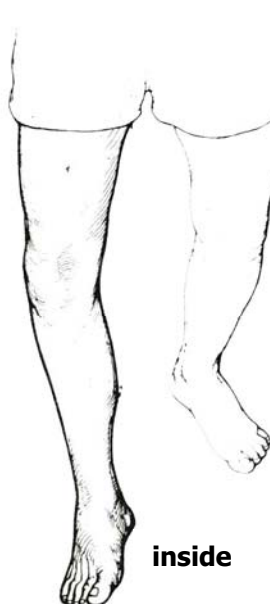
LEFT THIGH AND LEG: PLEASE MARK THE AREA(S) BELOW WITH

AN "X" FOR **SHARP PAIN**

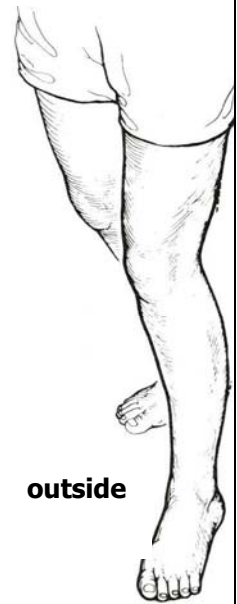
or an "O" FOR **NUMBNESS**.



RIGHT



LEFT



MY SYMPTOMS ARE:

- CONSTANT AND OCCURS EVERY DAY
- ARE INTERMITTENT BUT OCCUR EVERY DAY
- NOT PRESENT EVERY DAY

MY PAIN IS BEST DESCRIBED AS:

- SHARP SHOOTING
- DULL and ACHY
- BURNING

MY PAIN DURING THE DAY IS :

- None or I Ignore it.
- MILD, occasional
- MILD. Pain is present more with STAIRS and minimal pain with walking.
- MILD Pain is present with STAIRS and WALKING. But can perform most activities required.
- MODERATE pain during and after activities. NO pain at Rest (INTERMITTENT). Some limitations.
- MODERATE pain during and after activities. Pain present at rest and with activity (CONTANT) . Some limitations.
- SEVERE pain, present constantly but still able to walk and perform simple day-to-day activities. Many limitations

HOW DO YOU GO UP AND DOWN STAIRS?

- Normal both up and down. No rails needed.
- Normal going up the stairs, but need a hand rail going down
- Need a hand rail for going up and down the stairs
- I can go up the stairs using a hand rail, but I am unable to go down the stairs
- Unable to use stairs

WHAT IS YOUR WALKING DISTANCE?

- I have no restrictions. Unlimited walking distance
- Greater than 10 blocks.
- 5 to 10 blocks
- less than 5 blocks
- Housebound
- Unable to walk

WHAT TYPE OF SUPPORT DO YOU NEED WHEN WALKING?

- None
- Cane for long walks ONLY
- Cane at ALL times
- Two Canes
- Two Crutches
- Walker
- Unable to walk

HOW LONG HAVE YOU NEEDED A CANE OR CRUTCH OR WALKER TO WALK? _____

PLEASE CHECK (X) ANY OF THE ANTI-INFLAMMATORY MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTLY TAKING.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Motrin/Ibuprofen/ <i>Advil</i> | <input type="checkbox"/> Tylenol/Acetaminophen | <input type="checkbox"/> Tramadol/ <i>Ultram</i> | <input type="checkbox"/> Glucosamine Chondroitin Sulfate |
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Indomethacin/ <i>Indocin</i> | <input type="checkbox"/> Etodolac/ <i>Lodine</i> | <input type="checkbox"/> Prednisone |
| <input type="checkbox"/> Vioxx | <input type="checkbox"/> Naproxen/Naprosyn/ <i>Aleve</i> | <input type="checkbox"/> Diclofenac/ <i>Voltaren</i> | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Valdecoxib/ <i>Bextra</i> | <input type="checkbox"/> Piroxicam/ <i>Feldene</i> | <input type="checkbox"/> Oxaprozin/ <i>Daypro</i> | |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nabumetone/ <i>Relafen</i> | <input type="checkbox"/> Mobic | |

PLEASE CHECK (X) ANY OF THE PAIN RELIEVING AND MUSCLE RELAXING MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTLY TAKING.

- | | | | | |
|---|-----------------------------------|------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Codeine / Tylenol #3 | <input type="checkbox"/> Tylox | <input type="checkbox"/> Methadone | <input type="checkbox"/> Soma | <input type="checkbox"/> Robaxin |
| <input type="checkbox"/> Vicodin/Hydrocodone | <input type="checkbox"/> Percocet | <input type="checkbox"/> Dilaudid | <input type="checkbox"/> Flexaril | <input type="checkbox"/> Zanaflex |
| <input type="checkbox"/> Lortab | <input type="checkbox"/> Percodan | <input type="checkbox"/> Demerol | <input type="checkbox"/> Valium | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Darvocet | <input type="checkbox"/> Fioricet | <input type="checkbox"/> Roxicet | <input type="checkbox"/> Skelaxin | |

PLEASE CHECK (X) ANY OF THE FOLLOWING SIDE EFFECTS YOU MAY HAVE EXPERIENCED WHILE TAKING THE ABOVE MEDICATIONS

- | | | | |
|---------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> HEARTBURN or UPSET STOMACH | <input type="checkbox"/> STOOLS CHANGE COLOR (DARK) | <input type="checkbox"/> VOMITING |
| <input type="checkbox"/> NAUSEA | <input type="checkbox"/> ULCERS | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> OTHER: _____ |

DURING THE PAST 4 WEEKS HOW OFTEN HAVE YOU TAKEN MEDICATION FOR EACH JOINT?

	RIGHT KNEE	LEFT KNEE
ALWAYS (max dosage)	1	1
OFTEN (every day, but NOT maximum dosage)	2	2
SOMETIMES (3-5 times per week)	3	3
OCCASIONALLY(1-2 times per week)	4	4
NEVER	5	5

ARE THE MEDICATIONS THAT YOU ARE TAKING FOR YOUR PAIN RELIEVING YOUR SYMPTOMS?

- YES NO

HAVE YOU EVER BEEN TREATED OR EVALUATED AT A PAIN CLINIC?

- YES NO



PREVIOUS TREATMENT FOR YOUR RIGHT KNEE PAIN. PLEASE CHECK (X) those that apply.

TREATMENT	RIGHT KNEE		with relief		Last injection Date: _____	How many Treatments? _____
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
CORTISONE injection	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____	_____
SYNVISC/SUPARTZ injection	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____	_____
PHYSICAL THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
ACCUPUNCTURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
CHIROPRACTIC CARE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

PREVIOUS TREATMENT FOR YOUR LEFT KNEE PAIN. PLEASE CHECK (X) those that apply.

TREATMENT	LEFT KNEE		with relief		Last injection Date: _____	How many Treatments? _____
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
CORTISONE injection	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____	_____
SYNVISC/SUPARTZ injection	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____	_____
PHYSICAL THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
ACCUPUNCTURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
CHIROPRACTIC CARE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

PREVIOUS SURGERY TO THE KNEE(s):

DATE OF SURGERY	WHICH SIDE?	SURGEON/Hospital	PROCEDURE	COMPLICATIONS
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			

Knee Injury and Osteoarthritis Outcome Score (KOOS)

INSTRUCTIONS: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to do your usual activities.

Answer every question by checking the appropriate box. If you are unsure about how to answer a question, please give the best answer you can.

Symptoms - These questions should be answered thinking of your knee symptoms during the **last week**.

S1. Do you have swelling in your knee?				
Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?				
Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S3. Does your knee catch or hang up when moving?				
Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S4. Can you straighten your knee fully?				
Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S5. Can you bend your knee fully?				
Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S6GM. Does your knee buckle or give out?				
Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S7GM. Does your knee feel weak?				
Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S8GM. Do you have a limp?				
Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S9GM. Do you have any numbness around your knee or foot?				
Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Stiffness - The following questions concern the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

S6. How severe is your knee joint stiffness after first wakening in the morning?				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

S7. How severe is your knee stiffness after sitting, lying or resting later in the day ?				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Pain

P1. How often do you experience knee pain?				
Never	Monthly	Weekly	Daily	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What amount of knee pain have you experienced the **last week** during the following activities?

P2. Twisting/pivoting on your knee				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

P3. Straightening knee fully				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

P4. Bending knee fully				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

P5. Walking on flat surface				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

P6. Going up or down stairs				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

P7. At night while in bed				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

continued

P8. Sitting or lying				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

P9. Standing upright				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Function, daily living - The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A1. Descending stairs				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A2. Ascending stairs				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A3. Rising from sitting				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A4. Standing				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A5. Bending to floor/pick up an object				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A6. Walking on flat surface				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A7. Getting in/out of car				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

continued

A8. Going shopping				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A9. Putting on socks/stockings				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A10. Rising from bed				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A11. Taking off socks/stockings				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A12. Lying in bed (turning over, maintaining knee position)				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A13. Getting in/out of bath				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A14. Sitting				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A15. Getting on/off toilet				
None	Mild	Moderate	Severe	Extreme
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)				
Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

A17. Light domestic duties (cooking, dusting, etc)				
Never	Rarely	Sometimes	Often	Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Function, sports and recreational activities - The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your knee.

SP1. Squatting				
None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP2. Running				
None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP3. Jumping				
None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP4. Twisting/pivoting on your injured knee				
None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP5. Kneeling				
None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Quality of Life

Q1. How often are you aware of your knee problem?				
Never	Monthly	Weekly	Daily	Constantly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q2. Have you modified your life style to avoid potentially damaging activities to your knee?				
Not at all	Mildly	Moderately	Severely	Totally
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q3. How much are you troubled with lack of confidence in your knee?				
Not at all	Mildly	Moderately	Severely	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q4. In general, how much difficulty do you have with your knee?				
None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SF36 Health Survey

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please tick **one** box.)

Excellent

Very Good

Good

Fair

Poor

2. Compared to one year ago, how would you rate your health in general now? (Please tick **one** box.)

Much better than one year ago

Somewhat better now than one year ago

About the same as one year ago

Somewhat worse now than one year ago

Much worse now than one year ago

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? **(Please circle one number on each line.)**

<u>Activities</u>	Yes, Limited A Lot	Yes, Limited A Little	Not Limited At All
3(a) Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports	1	2	3
3(b) Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
3(c) Lifting or carrying groceries	1	2	3
3(d) Climbing several flights of stairs	1	2	3
3(e) Climbing one flight of stairs	1	2	3
3(f) Bending, kneeling, or stooping	1	2	3
3(g) Walking more than a mile	1	2	3
3(h) Walking several blocks	1	2	3
3(i) Walking one block	1	2	3
3(j) Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? **(Please circle one number on each line.)**

	Yes	No
4(a) Cut down on the amount of time you spent on work or other activities	1	2
4(b) Accomplished less than you would like	1	2
4(c) Were limited in the kind of work or other activities	1	2
4(d) Had difficulty performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g. feeling depressed or anxious)? **(Please circle one number on each line.)**

	Yes	No
5(a) Cut down on the amount of time you spent on work or other activities	1	2
5(b) Accomplished less than you would like	1	2
5(c) Didn't do work or other activities as carefully as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Please tick **one** box.)

Not at all

Slightly

Moderately

Quite a bit

Extremely

7. How much physical pain have you had during the past 4 weeks? (Please tick **one** box.)

None

Very mild

Mild

Moderate

Severe

Very Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Please tick **one** box.)

Not at all

A little bit

Moderately

Quite a bit

Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

(Please circle one number on each line.)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
9(a) Did you feel full of life?	1	2	3	4	5	6
9(b) Have you been a very nervous person?	1	2	3	4	5	6
9(c) Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
9(d) Have you felt calm and peaceful?	1	2	3	4	5	6
9(e) Did you have a lot of energy?	1	2	3	4	5	6
9(f) Have you felt downhearted and blue?	1	2	3	4	5	6
9(g) Did you feel worn out?	1	2	3	4	5	6
9(h) Have you been a happy person?	1	2	3	4	5	6
9(i) Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.) (Please tick **one** box.)

All of the time

Most of the time

Some of the time

A little of the time

None of the time

11. How TRUE or FALSE is each of the following statements for you?

(Please circle one number on each line.)

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
11(a) I seem to get sick a little easier than other people	1	2	3	4	5
11(b) I am as healthy as anybody I know	1	2	3	4	5
11(c) I expect my health to get worse	1	2	3	4	5
11(d) My health is excellent	1	2	3	4	5

Thank You!

- Which ONE of the following includes the highest level of formal schooling that you have had?
- No Formal Schooling
 - Elementary School
 - High School
 - Some College
 - College Degree
 - Graduate School

Are You married?

- Yes, married
- No, Never married
- No, divorced or separated
- No, widowed

Which ONE of the following best describes your living current living arrangement?

- I live alone in a house or apartment
- I live with my family in a house or apartment
- Assisted Living Center: *Location* _____
- Nursing Home: *Location* _____
- other (please Describe) _____

SOCIAL HABITS

DO YOU USE TOBACCO PRODUCTS?

YES NO.

- CHEWING TOBACCO CIGARS CIGARETTES PIPE

If **yes**, how many packs/cigars a day? _____. About what year did you start? _____.

HAVE YOU EVER USED TOBACCO?

YES NO.

If **yes**, how many years? _____. About what year did you quit? _____.

DO YOU DRINK ALCOHOL SOCIALLY?

YES NO.

If **yes**, how many drinks per week? _____.

DO YOU FEEL YOU DRINK ALCOHOL IN EXCESS?

YES NO.

DO YOU USE RECREATIONAL DRUGS?

YES NO.

HAVE YOU EVER USED RECREATIONAL DRUGS?

YES NO.

DO YOU HAVE ANY **ALLERGIES** TO MEDICATIONS?

YES NO.

- Penicillin Sulfa Codeine Betadine
 OTHER _____

DO YOU HAVE AN **ALLERGY** TO LATEX?

YES NO.

DO YOU HAVE ANY **ALLERGIES** TO FOOD?

YES NO.

MEDICAL PROBLEMS: check all that apply, Now or in the Past

- I HAVE NOT HAD ANY MEDICAL PROBLEMS OR PREVIOUS ILLNESSES**

General	NOW	PAST	Respiratory	NOW	PAST	GU (men)	NOW	PAST
Fever			Shortness of breath (SOB)			Testicular pain or masses		
Chills			Asthma			GU (women)		
Drenching night sweats			COPD/Emphysema			Irregular menses/amenorrhea		
Itching			T.B.			Dysmenorrhea		
Fatigue			Positive PPD or prior BCG			Hot flashes		
Change in weight			Pneumonia or bronchitis			Pregnancy loss		
Change in appetite			Wheezing			Extremities-muscles-joints		
HIV/AIDS			Chronic Cough			Osteoarthritis		
Alcoholism			Hemoptysis			Rheumatoid Arthritis		
Fibromyalgia			Pulmonary embolus			Gout		
Skin			Sleep apnea			Morning stiffness		
Jaundice			Any abnormal chest X-ray in past			Joint injuries		
Skin cancer (what kind)			Cardiovascular			Raynaud's		
Psoriasis			High Blood pressure			Morning stiffness		
Eczema			Chest pain or Angina			Back pain		
Head			Heart attack			Neck pain		
Headache/migraines			Murmur			Neurologic		
Other head pain			arrhythmia			Seizures or epilepsy		
Trauma			Atrial Fibrillation			Stroke		
Skull fracture			Normal Stress Test			Dizziness or vertigo		
Ears			Abnormal Stress Test			Tremor		
Decreased hearing			Dizziness			Involuntary movements		
Tinnitus or ringing			Syncope or near-syncope			Balance problems		
Discharge			Loss of consciousness			Numbness or tingling in Feet		
Infection			Edema or swelling in both feet			Numbness or tingling in Hands		
Pain			Blood clots			Memory concerns		
Eyes			Abdominal			Endocrine		
Pain			Pain			Thyroid problems		
Infection			Nausea/vomiting			Heat or cold intolerance		
Glaucoma			Change in bowel habits			Diabetes Type I (Insulin Requiring		
Dry eyes			Diarrhea or constipation			Diabetes Type II (oral medications)		
Macular degeneration			Bright red blood per rectum			Diabetes-borderline		
blindness			History of polyps			Excessive thirst		
Nose			Colon cancer			Frequent Fractures		
Frequent bleeding			Pancreatitis			Loss of height		
Sinus Problems			Gall bladder disease			Hematologic		
Changes in smell			Gallstones			Anemia		
Mouth/Throat			Irritable bowel syndrome (IBS)			Sickle Cell Disease		
Tongue problems			Inflammatory bowel disease (IBD)			Swollen lymph nodes		
Change in taste			Hepatitis			Blood diseases		
Mouth lesions or ulcers			Hernias			Leukemia/lymphoma		
Dentures			GU			Bleeding problems		
Dry mouth			Frequency			Blood clots		
Bleeding(mouth/gums)			Burning			Past use of blood thinners		
Gum disease			Blood in the urine			Psychiatric		
Problems swallowing			Kidney stones			Depressive symptoms (e.g. feeling down)		
Neck			Urinary tract infection (UTI)			Anxious		
Thyroid problems			Cystitis			Phobias		
Lumps, masses, nodules			Incontinence			OCD behaviors		
Breasts			Bladder cancer			ADD/ADHD behaviors		
Masses			Prostate cancer			Panic attacks		
Discharge			Uterus/cervical cancer			Hallucinations (visual/auditory)		
Pain						Suicidal/homicidal thoughts		
Cancer						Bipolar Disorder		

MEDICATIONS: Please list all medications you are taking including over-the-counter medications.

I DO NOT TAKE ANY MEDICATION

MEDICATION	DOSEAGE	HOW OFTEN
1.		
2.		
3.		
4.		

MEDICATION	DOSEAGE	HOW OFTEN
5.		
6.		
7.		
8.		

PERSONAL SURGICAL HISTORY

I HAVE NEVER HAD SURGERY

PLEASE CHECK ALL THAT APPLY AND GIVE APPROXIMATE **YEAR** SURGERY WAS PERFORMED.

ABDOMINAL SURGERY:

- | | | |
|--|---|---|
| <input type="checkbox"/> APPENDIX | <input type="checkbox"/> GASTRIC BYPASS | <input type="checkbox"/> ORGAN TRANSPLANT |
| <input type="checkbox"/> GALL BLADDER REMOVAL | <input type="checkbox"/> COLON RESECTION or COLOSTOMY | |
| <input type="checkbox"/> HERNIA REPAIR | <input type="checkbox"/> NISSEN (reflux surgery) | |
| <input type="checkbox"/> AORTIC ANEURYSM (AAA) | <input type="checkbox"/> REMOVAL OF SPLEEN | |

CARDIOVASCULAR SURGERY:

- | | | |
|--|--|---|
| <input type="checkbox"/> ANGIOPLASTY or STENT | <input type="checkbox"/> OPEN HEART SURGERY and BYPASS | <input type="checkbox"/> OPEN HEART SURGERY and VALVE SURGERY |
| <input type="checkbox"/> ARTERY BYPASS IN LEGS | <input type="checkbox"/> VEIN STRIPPING | <input type="checkbox"/> CAROTID (neck) ARTERY SURGERY |

MUSCULOSKELETAL:

- | | | |
|--|--|--|
| <input type="checkbox"/> CARPAL TUNNEL SURGERY | <input type="checkbox"/> FRACTURE REPAIR | <input type="checkbox"/> JOINT RELACEMENT SURGERY |
| <input type="checkbox"/> ARTHROSCOPY SURGERY | <input type="checkbox"/> CERVICAL/NECK SPINE SURGERY | <input type="checkbox"/> LUMBAR/LOWER BACK SURGERY |

OTHER:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> THYROID REMOVAL | <input type="checkbox"/> CATARACT SURGERY | <input type="checkbox"/> BRAIN SURGERY | <input type="checkbox"/> LASIX EYE SURGERY |
| <input type="checkbox"/> TONSILLECTOMY | <input type="checkbox"/> PLASTIC SURGERY | <input type="checkbox"/> SINUS SURGERY | |

FEMALES ONLY:

- | | | |
|---|---|--|
| <input type="checkbox"/> HYSTERECTOMY (uterus) | <input type="checkbox"/> TUBAL LIGATION | <input type="checkbox"/> C-SECTION |
| <input type="checkbox"/> OOPHORECTOMY (ovaries) | <input type="checkbox"/> BLADDER SUSPENSION SURGERY | <input type="checkbox"/> BREAST BIOSPY or MASTECTOMY |

MALES ONLY:

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> PROSTATE SURGERY | <input type="checkbox"/> VASECTOMY | <input type="checkbox"/> TESTICULAR SURGERY |
| <input type="checkbox"/> BREAST BIOSPY or MASTECTOMY | | |

OTHER SURGERY NOT LISTED ABOVE:

FAMILY HISTORY : DOES YOUR GRANDPARENTS, MOTHER, FATHER OR BROTHERS/ SISTERS OR CHILDREN HAVE ANY ON THE FOLLOWING MEDICAL PROBLEMS (LIVING OR DECEASED)?

Disease or Problem	yes	no	Relation
CANCER			
ANESTHESIA PROBLEMS			
TUBERCULOSIS			
Kidney problems			

Disease or Problem	yes	no	Relation
HEART DISEASE			
BLEEDING PROBLEMS			
CLOTTING PROBLEMS			
JOINT REPLACEMENT			

SIGN HERE

Signature of person filling out this form

Office use Only:

HIPS	Right	Left	KNEES	Right	Left
Flexion			Flexion		
Extension			Extension		
E.R.			Extensor lag		
I.R.			AP stability (mm)		
ABDUCTION			ML stability (degrees)		
ADDUCTION			Var/Val alignment		

Provider's signature and Date