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NEW PATIENT CONSULTATION FORM

NAME: ______________________________ **DATE OF BIRTH:** __________ **AGE:** _____

HEIGHT: ________ WEIGHT: ________ **SEX:** M F

REFERRING PHYSICIAN (NAME, PHONE AND **FAX** NUMBERS PLEASE):

____

TEL:__________________________FAX:______________________

PRIMARY CARE PHYSICIAN (IF DIFFERENT FROM ABOVE, PLEASE INCLUDE PHONE AND FAX):

____

____

MAY WE SEND A COPY OF THE NOTE TO YOUR PRIMARY CARE PHYSICIAN? ( ) YES ( ) NO

PHARMACY (NAME AND PHONE NUMBER): ______________________________

ARE YOU INVOLVED IN A LAWSUIT RELATED TO THE CONDITION THAT BRINGS YOU IN TODAY? YES NO

REVIEW OF SYSTEMS (CIRCLE ANY SYMPTOMS YOU EXPERIENCE REGULARLY): ( ) NONE

WEIGHT LOSS	WEIGHT GAIN	FATIGUE	HAIR LOSS	VERTIGO
COUGH	SHORTNESS OF BREATH	CHEST PAIN	DIARRHEA	RASHES
BLURRED VISION	POOR VISION	HEARING LOSS	RINGING IN EARS	TREMORS
UPSET STOMACH	CONSTIPATION	BLOODY STOOLS	OPEN SORES	ANXIETY
EASY BRUISING	EASY BLEEDING	POOR BALANCE	EXCESSIVE THIRST	
MOOD SWINGS	PALPITATIONS	PAINFUL URINATION	FREQUENT URINATION	

OTHER: ______________________ OTHER JOINT PAIN: ______________________

PAST MEDICAL HISTORY (PLEASE CIRCLE ANY CURRENT OR PAST MEDICAL CONDITIONS):

ANEMIA	ANGINA	ASTHMA	TIA
ATRIAL FIBRILLATION	BLADDER INFECTION	BRONCHITIS	STROKE
CANCER:____________	CELLULITIS	BLOOD CLOTS	FRACTURES
HEART DISEASE	DEPRESSION	DIABETES	GOUT
OSTEOARTHRITIS	DIVERTICULITIS	ELEVATED CHOLESTEROL	GLAUCOMA
EMPHYSEMA/COPD	EPILEPSY	HEART ATTACK	HIV
HEART ARRHYTHMIA	HEART VALVE DISEASE	HIGH BLOOD PRESSURE	SLEEP APNEA
RHEUMATOID ARTHRITIS	KIDNEY DISEASE	KIDNEY STONES	PNEUMONIA
LIVER DISEASE/HEPATITIS	PANCREATITIS	STOMACH ULCERS	LEUKEMIA
HIATAL HERNIA/REFLUX	SINUS PROBLEMS	OSTEOPOROSIS	DIALYSIS
THYROID DISORDERS	CONGESTIVE HEART FAILURE		

OTHER: ____

PAST SURGICAL HISTORY (PLEASE MARK ALL PREVIOUS SURGERIES): ( ) NONE

( ) C-SECTION ( ) CATARACT SURGERY ( ) HERNIA REPAIR ( ) HYSTERECTOMY

( ) PACEMAKER ( ) GALL BLADDER ( ) TURP ( ) APPENDECTOMY

( ) RIGHT KNEE ARTHROSCOPY ( ) LEFT KNEE ARTHROSCOPY

( ) RIGHT TOTAL KNEE REPLACEMENT ( ) LEFT TOTAL KNEE REPLACEMENT

( ) REPEAT RIGHT KNEE REPLACEMENT ( ) REPEAT LEFT KNEE REPLACEMENT

( ) RIGHT PARTIAL KNEE REPLACEMENT ( ) LEFT PARTIAL KNEE REPLACEMENT

( ) RIGHT TOTAL HIP REPLACEMENT ( ) LEFT TOTAL HIP REPLACEMENT

( ) REPEAT RIGHT HIP REPLACEMENT ( ) REPEAT LEFT HIP REPLACEMENT

OTHER SURGERIES: ____

PROBLEMS WITH ANESTHESIA? ( ) NO ( ) YES, PLEASE EXPLAIN: ______________________

PROBLEMS WITH FOLEY/BLADDER CATHETER: ( ) NO ( ) YES, PLEASE EXPLAIN: ______________

ELABORATE ON MEDICAL HISTORY IF NECESSARY:

____

____

MEDICATIONS, VITAMINS OR SUPPLEMENTS – PLEASE INCLUDE DOSAGES: ( ) NONE

____

____

____

____

ALLERGIES TO MEDICATIONS: ( ) NONE

____

ARE YOU ALLERGIC TO THE FOLLOWING?: METAL, IODINE, SHELLFISH

OTHER ALLERGIES: ______________________________

SOCIAL HISTORY:

HOW WOULD YOU DESCRIBE YOUR CURRENT WORK STATUS?

□ WORKING FULL TIME □ VOLUNTEER FULL TIME □ FULL TIME HOMEMAKER □ RETIRED

□ WORKING PART TIME □ VOLUNTEER PART TIME □ LAID OFF/UNEMPLOYED □ OTHER

OCCUPATION: ______________________

DO YOU SMOKE? ( ) NO ( ) YES - ________ PACKS PER DAY FOR ______ YEARS

DO YOU DRINK ALCOHOL? ( ) NO ( ) YES - HOW MUCH? ________________

ARE YOU ON DISABILITY? ( ) NO ( ) YES - FOR WHAT CONDITION? ______________________

WHERE DO YOU LIVE?

□ HOME WITH SPOUSE OR FAMILY □ LIVE ALONE □ RETIREMENT COMMUNITY □ NURSING HOME

FAMILY HISTORY:

IS THERE ANY FAMILY HISTORY OF THE FOLLOWING: (CIRCLE ALL THAT APPLY): ( ) NONE

STROKE CANCER HEART DISEASE ARTHRITIS DIABETES OTHER: ____________

IF YES, PLEASE EXPLAIN: ______________________________

PAIN

WHAT HURTS? ______________________ WHICH SIDE? LEFT RIGHT

RATE YOUR PAIN AT ITS WORST (0 = NO PAIN, 10 = WORST PAIN IMAGINABLE): _______

HOW LONG HAS IT BEEN HURTING? (IN DAYS/MONTHS/YEARS): ______________________

IS THE PAIN GETTING – [ ] BETTER [ ] WORSE [ ] STAYING THE SAME

WAS THERE AN INJURY? [ ] NO [ ] YES, PLEASE EXPLAIN: ______________________

WHERE DO YOU FEEL THE PAIN? (SELECT ALL THAT APPLY)

LEFT	*RIGHT*	
[ ]	[ ]	NOT APPLICABLE / NO PAIN
[ ]	[ ]	IN THE GROIN
[ ]	[ ]	IN THE FRONT OF THE THIGH
[ ]	[ ]	ON THE SIDE OF THE HIP
[ ]	[ ]	IN THE BEHIND
[ ]	[ ]	IN THE KNEE
[ ]	[ ]	IN THE LOWER BACK
[ ]	[ ]	RUNNING DOWN THE LEG (SCIATICA)

INDICATE THE AMOUNT OF PAIN YOU NORMALLY EXPERIENCE: (SELECT ONE):

LEFT	*RIGHT*	
[ ]	[ ]	NO PAIN
[ ]	[ ]	SLIGHT PAIN
[ ]	[ ]	MILD PAIN - NO AFFECT ON AVERAGE ACTIVITY
[ ]	[ ]	MODERATE PAIN - AFFECTS ACTIVITY SOMEWHAT
[ ]	[ ]	SEVERE PAIN

[ ] [ ] INTOLERABLE PAIN

WHEN DO YOU EXPERIENCE THIS PAIN? (SELECT ONE):

LEFT *RIGHT*

[ ] [ ] NEVER
[ ] [ ] OCCASIONALLY OR INTERMITTENTLY
[ ] [ ] WHEN I FIRST GET UP FROM A SITTING POSITION
[ ] [ ] ONLY AFTER WALKING MORE THAN 30 MINUTES
[ ] [ ] ANYTIME I WALK
[ ] [ ] AT NIGHT
[ ] [ ] AT ALL TIMES

DO YOU HAVE ANY OF THE FOLLOWING? (CIRCLE ALL THAT APPLY):

GROIN PAIN	LOW BACK PAIN	NUMBNESS	TINGLING	BURNING	FEVERS
WEAKNESS	NIGHT SWEATS	WARMTH/HEAT	STIFFNESS	LOCKING	CHILLS
REDNESS	GIVING WAY	*PAINFUL* CLICKING	SWELLING (OTHER THAN MILD)		

WHAT KIND OF MEDICATION DO YOU TAKE FOR PAIN? (SELECT ALL THAT APPLY): ( ) NONE

☐ NARCOTIC PAIN PILLS ☐ NON-NARCOTIC PAIN PILLS ☐ ARTHRITIS PILLS

☐ **INJECTIONS** ☐ OTHER: ______________________

NAME, STRENGTH AND DOSAGE OF THE MEDICATION: ______________________

WHEN DID YOU START TAKING THIS MEDICATION? (APPROXIMATE DATE): ______________________

HAVE YOU HAD PHYSICAL THERAPY FOR THE PROBLEM THAT BRINGS YOU IN? ☐ YES ☐ NO

WHEN DID YOU START? (APPROXIMATE DATE): ______________________

IF COMPLETED, WHEN DID YOU STOP? ______________________

HOW DO YOU GO UP STAIRS?

☐ NORMAL ☐ MUST USE RAILING ☐ TWO FEET ON EACH STEP ☐ UNABLE ☐ OTHER METHOD:________

HOW MANY CITY BLOCKS CAN YOU WALK BEFORE HAVING TO STOP BECAUSE OF PAIN? ________

COULD YOU USE PUBLIC TRANSPORTATION, SUCH AS BUS OR SUBWAY, IF YOU WANTED TO? YES NO

DO YOU NEED SUPPORT WHEN WALKING? ( ) NO

☐ CANE ☐ TWO CANES ☐ WALKER ☐ CRUTCHES ☐ UNABLE TO WALK

DO YOU HAVE TROUBLE OR DIFFICULTY PUTTING ON YOUR SHOES/SOCKS? YES NO

TO THE BEST OF MY KNOWLEDGE, EVERYTHING I HAVE ANSWERED ABOVE IS TRUE AND CORRECT.

PATIENT SIGNATURE: ______________________ DATE: ______________

HOOS, JR. HIP SURVEY

INSTRUCTIONS: This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.
Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

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

1. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

2. Walking on an uneven surface

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

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 hip.

3. Rising from sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

4. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

5. Lying in bed (turning over, maintaining hip position)

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

6. Sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

KOOS, JR. KNEE SURVEY

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 ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Stiffness
The following question concerns 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.

1. How severe is your knee stiffness after first wakening in the morning?

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

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

2. Twisting/pivoting on your knee

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

3. Straightening knee fully

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

4. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

5. Standing upright

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

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.

6. Rising from sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

7. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Global Health Scale

Please respond to each item by marking one box per row.

		Excellent	Very good	Good	Fair	Poor
Global01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global02	In general, would you say your quality of life is:...	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global03	In general, how would you rate your physical health?...	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global04	In general, how would you rate your mental health, including your mood and your ability to think?...	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global09	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)..................	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

		Completely	Mostly	Moderately	A little	Not at all
Global06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?...	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

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In the past 7 days...

		Never	Rarely	Sometimes	Often	Always
Global10	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

		None	Mild	Moderate	Severe	Very severe
Global08	How would you rate your fatigue on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Global07	How would you rate your pain on average?	☐ 0 No pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 Worst imaginable pain

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