Orthopaedic Associates of Zanesville
2854 Bell Street Zanesville, Ohio 43701 P: 740-454-3273 F: 740-588-1081 www.orthozane.com

KNEE HISTORY

Patient Name:_____ **DOB:**_____ **Date:**_____

CHIEF COMPLAINT (Briefly, what brings you here):

_____

_____

Is today's condition a result of an accident? ***Yes*** _____ ***No*** _____

If "yes", please circle: ***auto accident*** ***work accident*** ***other***

- Which Knee? **Right or Left**

HISTORY OF PRESENT ILLNESS:

- Describe your symptoms (e.g. location, constant/intermittent, sharp/dull, frequency)

_____

_____

_____

- How severe is it? (1-10 scale) _____ How long have you had it? _____
- What aggravates the pain? (please circle all that apply):
  - Stairs
  - Twisting/Pivoting
  - Biking
  - Stooping/Squatting
  - Jumping
  - Running
  - Other:_____
- Any "mechanical" symptoms? (please circle all that apply):
  Locking Popping Catching Giving way
- How far can you walk before having knee pain? (circle one)
  1 step 10 feet city block no limit
- Is the knee stiff? (Have you lost motion) Yes or No
- Do you have night pain? Yes or No
- Do you work out with weights? Yes or No
- Any swelling? Yes or No
- Any history of trauma?
  If "yes" when and how? _____
- Any previous knee surgery? Yes or No
  If "yes" when and what kind? _____

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KNEE HISTORY (cont'd)

- Prior injections? (Cortisone, "Gel" or Visco) Yes or No
- Any pain in the hip or groin? Yes or No
- Do any of the following decrease your pain?
  - Rest: Yes Minimally No
  - Ice: Yes Minimally No
  - Heat: Yes Minimally No
  - Over the counter meds (Tylenol/Advil) Yes Minimally No
  - Prescription meds: Yes Minimally No
- Is there anything else that decreases your pain? _____
  _____
- Any previous X-rays or MRI's? Yes or No
- Have you seen any other doctor for this problem? Yes or No
  If "yes" who and when? _____
- Have you ever had a problem with this knee before (or on the other side)?
  If "yes" explain _____
- Have you fallen due to a knee condition? Yes or No
- Describe your usual daily activity/work activity: (please circle all that apply)
  - Sedentary
  - Walking
  - Active
  - Standing
  - Lifting
  - Climbing
  - Other: _____
- What is your job description? _____
- Do you have a good appetite? Yes or No
- Have you had unexpected weight loss? Yes or No

CURRENT MEDICATIONS (include non-prescription meds and herbal supplements, etc.
14 medication(If more than s, please list on a separate sheet)

Name of Medication Dose How Often?	Name of Medication Dose How Often?

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KNEE HISTORY (cont'd)

ALLERGIES:

Medications (Please describe) None _____ Yes _____

_____

_____

Latex None _____ Yes _____

Metal None _____ Yes _____