PROLIANCE ORTHOPAEDICS & SPORTS MEDICINE
BELLEVUE • ISSAQUAH • REDMOND

A Service of PROLIANCE SURGEONS®

HIP AND KNEE INTAKE

Appointment Date_____

Name _____ **Age** _____ **Date of birth** _____

Height: _____ **Weight:** _____

PROVIDER SECTION ONLY

CC: _____ Onset: _____

Duration: _____ Location of pain: _____

Description of pain: _____

Aggravation Factors: _____ Relieving Factors: _____

Prohibits (limitations due to condition): _____

Referring Physician / Location _____

Primary Physician / Location _____

How did you hear about us? _____

What is the reason for your visit today?

☐Right Knee ☐Left Knee ☐Right Hip ☐Left Hip

Other (Please indicate) _____

How far can you walk without needing rest?

☐Indoors only ☐Less than 1 block ☐2-3 blocks ☐4-6 blocks ☐Not Limited

Do you need assistance walking?

☐No assistance ☐Cane ☐Crutches ☐Walker ☐Wheelchair

How do you manage stairs?

☐Without difficulty ☐Need Banister ☐Banister, 1 step at a time ☐Can't do stairs

Can you sit in a chair?

☐Any chair, at least 1 hour ☐Some chairs, ½ hour or less ☐Can't sit

How do you arise from a chair?

☐Normally ☐Need arm assistance ☐Difficult, need both arms ☐Need someone to help ☐Unable

Can you reach your socks or shoes?

☐Easily ☐With difficulty ☐Unable

Please rate the intensity of your joint pain/discomfort when at rest:

(0=No pain, 10=Severe pain)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Please rate the intensity of your joint pain/discomfort with activity or weight bearing:

(0=No pain, 10=Severe pain)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Have you had any of the following treatments for your joint problem?

Medications	☐Yes	☐No	If yes, please list: _____
Injections	☐Yes	☐No	If yes, please list: _____
Physical Therapy	☐Yes	☐No	Location: _____
Glucosamine/Chondroitin	☐Yes	☐No	
Other	☐Yes	If yes, please list: _____	

Allergies (please check box to any that apply and the type of reaction you experience)

☐No known drug allergies ☐Penicillin (PCN) _____

☐Sulfa _____ ☐Ibuprofen _____

Other _____

Past Medical History

☐Allergies
☐Anxiety
☐Asthma
☐Bipolar
☐Bleeding/Clotting Disorder
☐Cancer
☐Chemical/Alcohol Dependency
☐Chronic Lung Disease/Emphysema (COPD)
☐Congestive Heart Failure (CHF)
☐Coronary Artery Disease (CAD)
☐Depression
☐Diabetes (using insulin)
☐Diabetes (No insulin)
☐Fibromyalgia
☐Heartburn/Reflux (GERD)
☐Heart attack
☐Hepatitis _____(please specify)
☐High Blood Pressure
☐High Cholesterol
☐Psoriasis
☐Rheumatoid Arthritis (RA)
☐Stomach Ulcers/Ulcer Disease
☐Stroke/Transient Ischemic Attack (TIA)
☐Thyroid Disorder _____
☐Sleep Disorder/Insomnia
☐Sleep Apnea
OTHER _____
_____

Medications	**Dose**	**Times Per Day**	**Reason you are taking**
1.			
2.			
3.			
4.			
5.			

PLEASE USE A SEPARATE PAGE IF UNABLE TO LIST ALL MEDICATIONS

Family History (Check all that applies and please list family member)

☐Arthritis _____ ☐Cancer _____ ☐Clotting Disorder _____

☐Diabetes _____ ☐High Blood Pressure _____

☐Rheumatoid _____ Other _____

Bone/Joint Surgeries (Orthopedic)

Procedure	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries ☐No Previous Surgeries

☐Appendix _____

☐Gall Bladder _____

☐By-Pass/Open Heart _____

☐Hernia Repair _____

☐Hysterectomy_____

☐Tonsil removed (Tonsillectomy)_____

OTHER PROCEDURES/YEAR

_____

_____

_____

Social History

Work Status? ☐Employed (please list current occupation) _____

☐Unemployed ☐Disabled ☐Student ☐Retired

Marital Status?

☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner ☐Separated

Do you have children?

☐Yes ☐No If yes, how many? _____

Do you smoke?

☐Yes ☐No If yes, how much per day? _____

Do you use Recreational Drugs?

☐Yes ☐No If yes, what substance? _____

How often? _____

Do you drink alcohol?

☐Yes ☐No If yes, how much? _____ drinks per week

Do you have stairs in your home?

☐Yes ☐No If yes, how many? _____into house _____into bedroom

Review of Systems (please check)	Yes	No
General (Fever, Night sweats/Chills)	☐	☐
Vision (Glasses/Contacts, Cataracts, Glaucoma)	☐	☐
Ear/Nose/Throat (Sinus trouble, hearing loss)	☐	☐
Cardiac (Chest pain)	☐	☐
Pulmonary (Shortness of breath, difficulty breathing)	☐	☐
Gastrointestinal (Heartburn)	☐	☐
Musculoskeletal (Joint pain, Muscle pain)	☐	☐
Genitourinary (Painful urinating)	☐	☐
Skin (Non-healing wounds)	☐	☐
Neurologic (Seizures, numbness/tingling)	☐	☐
Psychiatric (Anxiety/Depression)	☐	☐
Endocrine (Frequent urination, excessive thirst)	☐	☐
Hematological (Bleeding/Clotting problems)	☐	☐
Allergic/Immunological (HIV/AIDS)	☐	☐
Do you have any history of infections (MRSA/Staph)	☐	☐

Are there any others that are not listed that we should know about?

_____

_____

PHYSICAL EXAM