PROLIANCE ORTHOPAEDICS & SPORTS MEDICINE
BELLEVUE • ISSAQUAH • REDMOND

Hip and Knee Intake

Name _____ **Age** _____ **DOB** _____

Referring Physician/Location _____

Primary Care 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 ☐ Cants 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 and 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**

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Height: _____ **Weight:** _____

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 ☐ No If yes, please list: _____

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

☐ No known drug allergies
☐ Sulfa _____
☐ Other _____
☐ Penicillin (PCN) _____
☐ Ibuprofen _____

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)
☐ Heat 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
☐ OTHER _____
_____
_____

Medications	Dose	Times Per Day	Reason you are taking
1.			
2.			
3.			
4.			
5.			
6.			

PLEASE USE A SEPARATE PAGE IF UNABLE TO LOG ALL MEDICATIONS

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

☐ Arthritis _____ ☐ Cancer _____ ☐ Clotting Disorder_____
☐ Diabetes _____ ☐ High Blood Pressure _____
☐ Rheumatoid _____ ☐ Other _____

Bone/Joint Surgeries (Ortho)

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

Surgeries

☐ No Previous Surgeries
☐ Appendix _____
☐ Gall Blatter _____
☐ By-Pass/Open Heart _____
☐ Hernia Repair _____
☐ Hysterectomy _____
☐ Tonsils 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 so, how many? _____

Do you smoke?

☐ Yes ☐ No If yes, how much per day? _____
When did you start smoking? _____ If quit, when? _____

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

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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?

_____

_____

PROVIDER SECTION ONLY

CC: _____ **Onset:** _____

Duration: _____ **Location of pain:** _____

Description of pain: _____

Aggravating Factors: _____ **Relieving Factors:** _____

Prohibits (limitations due to condition): _____