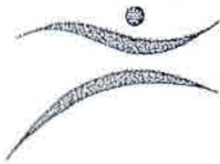

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Briefly explain the reason for your visit/problem:

____

____

____

____

____

Where is your primary pain?

Hip: Right | Left | Both

Where specifically: Groin | Thigh | Buttock | Side of hip

Knee: Right | Left | Both

Where specifically: Inner | Outer | Back | Kneecap | Entire knee

How long have you had pain?: __________ Days Weeks Months Years

What type of pain are you having (sharp, aching, burning, etc.)?:

How intense is your pain?: (answer below)

At rest? None | Mild | Moderate | Severe

With Activity? None | Mild | Moderate | Severe

Timing of pain?: Constantly | Intermittently

Does pain radiate or travel? Yes No If so, where?

What activity bothers you the most? ______________________________

Swelling?: None Constant Intermittent

Stiffness?: None Morning After activity

Have you experienced any of the following?: (Circle all that apply)

Catching Popping Locking Grinding Other: ________________________

Function:

Do you use a walking aid?	None | Occasional cane | Full time cane | Walker | Wheelchair
How far can you walk?	Unable | Household | 1-2 blocks | 3-5 blocks | 6-10 blocks | Unlimited
How do you manage stairs?	Unable | Non-reciprocating | Reciprocating with rail | Normal no rail
Putting on socks?	Unable | Very difficult | Mild difficulty | No problem
Getting out of chair/car?	Unable | Very difficult | Mild difficulty | No problem
Sleep?	Awaken with pain | Able to sleep without pain
Other functional problems?:	______________________________

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Prior Treatments?	Yes?			
Rest	☐	Very helpful	Somewhat	Not helpful
Activity modification	☐	Very helpful	Somewhat	Not helpful
NSAID	☐	Very helpful	Somewhat	Not helpful
Tylenol	☐	Very helpful	Somewhat	Not helpful
Glucosamine	☐	Very helpful	Somewhat	Not helpful
Narcotics	☐	Very helpful	Somewhat	Not helpful
Cortisone injections	☐	Very helpful	Somewhat	Not helpful
"Gel" injections	☐	Very helpful	Somewhat	Not helpful
Brace	☐	Very helpful	Somewhat	Not helpful
Physical therapy/Exercises	☐	Very helpful	Somewhat	Not helpful
Surgery	☐	Very helpful	Somewhat	Not helpful
Other	☐	Very helpful	Somewhat	Not helpful

Review of systems – Have you experienced any of the following symptoms?

	Yes	No	Describe all "Yes" responses
Fevers			
Unexplained weight loss			
History of DVT			
Sleep apnea			
Eyes (e.g. blurred vision, loss of vision)			
Ears, Nose, Throat (e.g. sore throat, earache, ringing)			
Cardiovascular (e.g. chest pain, palpations, ankle swelling)			
Respiratory (e.g. shortness of breath, cough, snore)			
Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)			
Genitourinary (e.g. burning, bleeding, difficuly urinating)			
Musculoskeletal (e.g. joint, neck, muscle, back pain)			
Skin (e.g. rash, cellulitis, psoriasis, delayed healing)			
Mental health (e.g. depression, anxiety, memory loss)			
Endocrine (e.g. weight loss/gain, excess thirst or urination)			
Hematologic (e.g. bruising, bleeding, or clotting disorder)			
Immunology (e.g. rash, swelling, wheezing)			