

# Hip and Knee Pain Questionnaire

## Dr. Adam Rosen

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Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Male / Female (circle one)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Please provide information of your doctor (s) if you would like them to receive information regarding your care/treatment:

Primary Care Doctor (Name, address and phone number):

\_\_\_\_\_

Specialty Doctors (such as cardiologist)

\_\_\_\_\_

**Chief Complaint** (please indicate right or left):

\_\_\_\_\_

\_\_\_\_\_

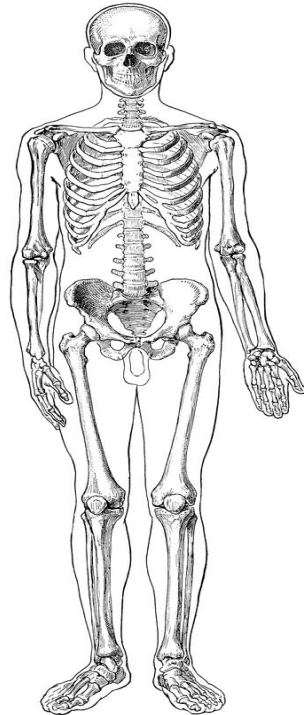
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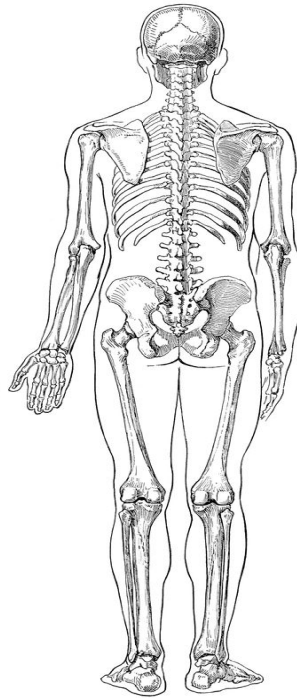
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Please circle/indicate where you are experiencing symptoms:

Front



Back



If this was a specific injury, when did it occur? \_\_\_\_\_

Please rate your pain on a scale of 0-10, 0 being no pain: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

What makes your problem better? \_\_\_\_\_

What makes your problem worse? \_\_\_\_\_

Do you feel that your legs are unequal? \_\_\_\_\_

How would you describe your symptoms (check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> mild              | <input type="checkbox"/> occasional            |
| <input type="checkbox"/> moderate          | <input type="checkbox"/> constant              |
| <input type="checkbox"/> severe            | <input type="checkbox"/> wakes you up at night |
| <input type="checkbox"/> aching            | <input type="checkbox"/> stabbing              |
| <input type="checkbox"/> sharp             | <input type="checkbox"/> throbbing             |
| <input type="checkbox"/> dull              | <input type="checkbox"/> sore                  |
| <input type="checkbox"/> clicking/catching | <input type="checkbox"/> radiating/shooting    |
| <input type="checkbox"/> swollen           | <input type="checkbox"/> unstable/giving out   |
| <input type="checkbox"/> numb              | <input type="checkbox"/> stiffness             |
| <input type="checkbox"/> tingling          | <input type="checkbox"/> other _____           |

Previous treatments have included (check all that apply):

- Rest
- Ice or Heat
- Oral anti-inflammatories (Advil, Aleve, ibuprofen, Naprosyn, etc.)
- Tylenol
- Narcotics (please specify): \_\_\_\_\_
- Brace
- Physical Therapy (if yes, when?) \_\_\_\_\_
- Cortisone injections: date \_\_\_\_\_
- Viscosupplementation injections (please circle): date: \_\_\_\_\_

Synvisc    Hyalgan    Supartz    Euflexxa    Orthovisc

Use of assistive device (please circle):

Cane      Crutches      Walker      Wheelchair

Other: \_\_\_\_\_

How far can you walk?

- unlimited
- 4-6 blocks
- 2-3 blocks
- indoors only
- limited to bed to chair transfers

How do you use stairs?

- normally (one foot on each step)
- with railing for support
- with great difficulty
- unable to climb stairs

How do you apply socks and shoes?

- with ease
- with difficulty
- unable to

How long can you sit in a chair?

- greater than 1 hour
- comfortably for ½ hour
- unable to sit comfortably

If needed could you use public transportation (bus, subway, train, etc.)?

- yes, with ease
- yes, with difficulty
- no

**Medical History** (please check all that apply):

- Anemia
- Arthritis
- Asthma
- Bleeding Disorder
- Blood Clots
- Cancer (please specify): \_\_\_\_\_
- Coronary Artery Disease (heart attack and/or stroke)
- Depression
- Diabetes
- Gout
- High Cholesterol
- Hypertension (high blood pressure)
- Infectious Disease (please specify): \_\_\_\_\_
- Kidney Disease
- Liver Disease
- Osteoporosis
- Reflux
- Spinal Stenosis
- Thyroid Disease
- Other (please specify): \_\_\_\_\_

**Surgical History** (please list past surgeries, doctor and approximate dates):

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**Medications**, including over the counter and/or herbals:  
(please list medication, dose, and frequency)

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**Allergies** (please list):

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**Social History** (please check all that apply):

Single     Married     Separated / Divorced     Widowed

Live alone

Alcohol Use (how much and how often): \_\_\_\_\_

Tobacco Use (how much and how often): \_\_\_\_\_

Illicit Drug Use (what, how much, and how often): \_\_\_\_\_

Occupation (please specify): \_\_\_\_\_

Retired

Disabled

Exercise (what type and how often): \_\_\_\_\_

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**Review of Systems**

(Indicate if you have experienced any of the following in the recent past)

Constitutional

- fever
- chills
- recent weight gain \_\_\_ lbs
- recent weight loss \_\_\_ lbs

Eyes

- blurry vision
- glaucoma
- dry eyes
- eye infection

ENT

- ringing in the ears
- sore throat
- hoarseness

Cardiovascular

- slow heart rate
- fast heart rate
- chest pain
- palpitations
- lower extremity edema

Respiratory

- shortness of breath
- wheezing
- cough

Heme/Lymph

- easy bleeding
- easy bruising

Musculoskeletal

- muscle pain
- joint pain
- joint swelling
- joint stiffness

Integumentary

- skin rash
- skin wound
- itching

Neurological

- numbness
- dizziness
- fainting
- headaches

Gastrointestinal

- difficulty swallowing
- heartburn
- nausea
- vomiting
- constipation

Genitourinary

- dysuria
- incontinence

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_