

Michael P. Leathers, MD

Orthopaedic Surgeon Specializing in

Sports Medicine/Shoulder, Hip and Knee Reconstruction

KNEE HISTORY AND PHYSICAL

Name:

Age:

Date:

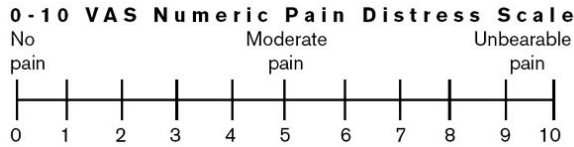
What side is the problem? Left Right Both

Email Address:

Height:

Weight:

Circle a number from 0-10 that best describes how much pain you are having **RIGHT NOW**.



For a child or non-english speaking adult, use the **FACES**® pain rating scale below:



Please list any **ALLERGIES** you have to medications or food/substances

None

Please list all **prescription medications** on the **ATTACHED sheet** or check "None"

None

Check the Box if you have:

NONE OF THE BELOW

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcohol Abuse or Dependence | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> MRSA Infection/Colonization |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Opioid Dependence |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> TIA |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Other | <input type="checkbox"/> Other |

Past Medical History:

NONE OF THE BELOW

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anesthetic Complications | <input type="checkbox"/> Ankylosing Spondylitis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Baker's Cyst |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Bone Cyst |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fibromyositis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Ganglion Cyst |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Intestinal Disease | <input type="checkbox"/> Kyphosis | <input type="checkbox"/> Nerve/Muscle Disease |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Paget's Disease of Bone |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinus Disorder |
| <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Spondylolisthesis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Other | <input type="checkbox"/> Other |

Past Surgical History:

Date

Date

Date

- | | | | | | |
|---|-------|---|-------|---|-------|
| <input type="checkbox"/> Abdomen Surgery | _____ | <input type="checkbox"/> Foot Fracture Surgery | _____ | <input type="checkbox"/> Knee Arthroscopy | _____ |
| <input type="checkbox"/> Ankle Fracture Surgery | _____ | <input type="checkbox"/> Foot Surgery | _____ | <input type="checkbox"/> Knee Surgery | _____ |
| <input type="checkbox"/> Back Surgery | _____ | <input type="checkbox"/> Hand Surgery | _____ | <input type="checkbox"/> Laminectomy | _____ |
| <input type="checkbox"/> Carpal Tunnel Release | _____ | <input type="checkbox"/> Heart Surgery | _____ | <input type="checkbox"/> Shoulder Arthroscopy | _____ |
| <input type="checkbox"/> Elbow Fracture Surgery | _____ | <input type="checkbox"/> Hip/Femur Fracture Surgery | _____ | <input type="checkbox"/> Shoulder Surgery | _____ |
| <input type="checkbox"/> Elbow Surgery | _____ | <input type="checkbox"/> Humerus Fracture Surgery | _____ | <input type="checkbox"/> Spinal Fusion | _____ |
| <input type="checkbox"/> Other | _____ | <input type="checkbox"/> Joint Replacement | _____ | <input type="checkbox"/> Wrist fracture Surgery | _____ |

Family History:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Clotting Disorders | <input type="checkbox"/> Osteoarthritis |

Physician Signature _____ Date _____

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Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Smokeless Tobacco Packs per day: _____ Years of use: _____ Quit Date: _____	Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks/Week: _____
History of illegal drug use: <input type="checkbox"/> Yes <input type="checkbox"/> No Last use date: _____ If yes, what type? _____	

Check and explain if you have any of the following symptoms CURRENTLY:

NONE OF THE BELOW

<input type="checkbox"/> Headache, dizziness, visual problems	
<input type="checkbox"/> Ear, nose or throat problem	
<input type="checkbox"/> Chest pain, irregular heartbeat, palpitations	
<input type="checkbox"/> Lung problems, asthma, shortness of breath	
<input type="checkbox"/> Difficulty or frequent urination	
<input type="checkbox"/> Nausea, vomiting, diarrhea, heartburn	
<input type="checkbox"/> Loss of sensation in your arms or legs	
<input type="checkbox"/> Vascular disease	
<input type="checkbox"/> Diabetes, thyroid or other endocrine problems	
<input type="checkbox"/> Easy bruising	
<input type="checkbox"/> Fevers, chills, night sweats	
<input type="checkbox"/> Recent weight loss or gain	

When did you start to have pain?			
Was there a specific injury (if so, what happened)?			
When you were injured: Did you hear/feel a pop? <input type="checkbox"/> Yes <input type="checkbox"/> No Did your knee swell? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please list any previous knee surgeries below 		
Do you currently have: Feelings of instability? <input type="checkbox"/> Yes <input type="checkbox"/> No Catching or locking? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Where do you feel the pain? <input type="checkbox"/> Front of the knee <input type="checkbox"/> Back of the knee <input type="checkbox"/> Inside of the knee <input type="checkbox"/> Outside of the knee Does the pain shoot down into the foot? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have numbness or tingling in the foot? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have pain in your back?	What previous treatments have you tried: <input type="checkbox"/> None <input type="checkbox"/> NSAIDS (<i>Motrin, Ibuprofen</i>) Helpful? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Narcotics (<i>Codeine, Vicodin</i>) Helpful? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Physical Therapy Helpful? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Injections Helpful? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Surgery Helpful? <input type="checkbox"/> Y <input type="checkbox"/> N		
What makes the pain better	How do you describe the pain? <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Sharp <input type="checkbox"/> Throbbing		
What makes the pain worse?			
Occupation?			
What sports/activities do you participate in?			
Sport	Level	Hours/Week	Weeks/Year

What questions can I answer for you today?

1. _____
2. _____
3. _____

Physician Signature _____ Date _____

