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Name: _____ **AGE:** _____ **DATE:** _____

-The "BODY PART" identified for today's appointment (please circle what applies for this visit):

Left or Right: Knee—Hip—Shoulder—Elbow—Wrist—Hand

Other: _____

-The "BODY PART" was normal until when? _____

-Pain level on "1-to-10" scale (Note: "10" is consistent with near LOSS OF CONSCIOUSNESS): _____

-What does your pain keep you from doing? _____

DESCRIBE YOUR PAIN : (CIRCLE ALL THAT APPLY) :

ACHY.....STABBING.....SHARP.....DULL.....BURNING.....ELECTRICAL

-Do you have mostly pain with walking? **Yes** _____ **No** _____

-Are there other specific features of your pain you can describe? _____

FOR KNEES ONLY:

-Do you have swelling? **Yes** _____ **No** _____

-Can you sleep on your side with your knees touching/resting on each other? **Yes** _____ **No** _____

-Does it hurt to "twist" your knee when:

Getting into and out of your car? **Yes** _____ **No** _____

Walking with a sudden "pivot/twist" in one direction or another? **Yes** _____ **No** _____

Tapping something out of your path with a "twist" of your foot? **Yes** _____ **No** _____

-Can you squat? **Yes** _____ **No** _____

What's worse (circle): Going "down" into the squat or coming "up" out of it?

-Does your knee "lock" on you? **Yes** _____ **No** _____

("Locking" is when your knee is straight & you can't bend it...or visa/versa)

-Does it "give-way"? **Yes** _____ **No** _____

Describe: _____

NAME: _____ **AGE:** _____ **DATE:** _____

- Can you go "up" & "down" stairs/slopes? **Yes** _____ **No** _____
What's worse (circle): going "up" or going "down"
With stairs, must you take "one-at-a-time?" **Yes** _____ **No** _____
Must you hold onto the railing for support? **Yes** _____ **No** _____

FOR HIPS ONLY :

-Where is your pain located? Front (groin area).....Side.....Low back area
Describe : _____

- Are you unable to do any of the following activities:
Bend forward to touch your toes? **Yes** _____ **No** _____
Put your shoes and socks on? **Yes** _____ **No** _____
Cross affected leg over the other? **Yes** _____ **No** _____
Sleep on the affected side? **Yes** _____ **No** _____

- Does your pain radiate:
Down into your knee(s)? **Yes** _____ **No** _____
Below the knee and into your foot ? **Yes** _____ **No** _____

IN GENERAL :

- Have you or any of your family members ever been tested/treated for any of the following:
Rheumatoid Arthritis? **Yes** _____ **No** _____
Gout? **Yes** _____ **No** _____
Lupus? **Yes** _____ **No** _____
Other? **Yes** _____ **No** _____

- Are you or have you ever taken medicine to decrease your pain? **Yes** _____ **No** _____

If so, please list: _____

- Do you take the supplement, *Glucosamine & Chondroitin*? **Yes** _____ **No** _____

- Do you have any allergies/sensitivities to specific food groups or products? **Yes** _____ **No** _____

If so, please list: _____

- Have you ever taken steroids or had medications injected into your joints? **Yes** _____ **No** _____

*If so, which joint and when, then, how much pain relief did you get (circle)?

None.....25%.....50%.....75%.....95%

Product injected and approximate date(s): _____

IF OVER THE AGE OF 50:

- Have you ever had a DEXA or bone density test? **Yes** _____ **No** _____

If so, where & when was your last exam ? _____

- Have you ever been told you have 'Osteoporosis' or 'Osteopenia?' **Yes** _____ **No** _____

- Are you losing height ? **Yes** _____ **No** _____

- Do you take medicine, hormones or calcium supplements specifically for your bones? **Yes** _____ **No** _____

If so, what and for how long? _____