



14198

Sports Knee Patient History

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Medical Record Number

10 digit grid for Medical Record Number

Date of Visit

MM/DD/YYYY grid for Date of Visit

First Name

15 digit grid for First Name

Middle

3 digit grid for Middle

Last Name

24 digit grid for Last Name

Suffix Sr. Jr. III IV M.D. PhD

Date of Birth

MM/DD/YYYY grid for Date of Birth with labels: month, day, year (4 digit ex. 1922)

Gender

Female Male

Race

African American Asian Caucasian Hispanic Native American Other _____

Marital Status

Single Married Living with significant other Divorced Separated Widowed

Location of Problem

Right knee Left knee

If you are seeing us for more than one problem, which ONE is the worst?

Right knee Left knee

Please describe your current problem (If you are seeing the doctor for multiple problems, answer for the most severe)

- New Injury or problem (less than 6 weeks duration)
- Subacute problem (began slowly with no identifiable cause and progressively worsened)
- Chronic problem (problem has been present over time period of more than 3 months and never been restored to normal)
- Re-injury (you injured this same area before, received treatment, had no problems until this new injury occurred)

Date problem began (approximate if unsure)

MM/DD/YYYY grid for Date problem began

Date of re-injury

MM/DD/YYYY grid for Date of re-injury

Is your problem a result of an injury? Yes No

ANSWER THE QUESTIONS IN THIS BOX ONLY IF YOUR PROBLEM IS THE RESULT OF AN INJURY

If your problem is the result of an injury, where did it occur? (check one answer only)

Home Work Motor vehicle accident Exercise Sport Competition Other (specify) _____

What caused your injury?

- Fall Fighting
- Lifting Twisting
- Throwing Collision/Contact
- Reaching Other (specify) _____
- Pulling

Check any of the following that happened at the time of your injury

Felt pain Heard popping Had swelling Dislocation Fracture Other (specify) _____

Have you talked to a lawyer about today's problem? Yes No

Are you receiving or have you applied for workers compensation concerning your injury? Yes No

Have you received previous treatment for your current problem? Yes No

If yes, please specify treatment type (**check all that apply**) and provide the **# of the procedures** or **weeks of physical therapy** you have had for the specific problem you are seeing the doctor for today

- ER Visit chiropractic
- oral medicine massage therapy
- physical therapy # of weeks acupuncture
- surgical # of surgeries other _____
- injections # of injections (specify)

Please tell us your height and weight

Height

ft inches

Weight

pounds



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Please check any of the following conditions you have or have had in the past. If you are unsure, please ask a staff member to assist you in filling out this form.

You may check more than one condition.

Medical Condition History Check this box if you have no medical problems [] no medical problems

- Alcoholism, Anemia, Anxiety, Asthma, Arthritis - rheumatoid, Arthritis - osteo, degenerative, Blood Clot, Blood Transfusion, Bowel disease, Cancer, Cardiac Arrhythmia, Congestive Heart Failure, Coronary Artery Disease, Cerebrovascular Disease, COPD, Diabetes, Depression, Fibromyalgia, GERD, Gout, Heart Attack, Hypertension, Hypercholesterolemia, Hypothyroidism, Kidney Disease, Liver Disorder - Cirrhosis, Liver Disorder - Hepatitis, Lung Disease, Osteomyelitis, Parkinson's, Ulcer Disease, Other

Surgery/ Procedures These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

Have you ever had surgery? Yes No

- Ear, Nose, Throat Procedures: Deviated Septum, Sinus Repair, Tonsillectomy, Tracheostomy, Vocal Cord Surgery
Gastrointestinal Procedures: Appendectomy, Cholecystectomy, Colon Resection, Exploratory Laparoscopy, Hernia, Liver Resection, Small Bowel Obstruction Repair, Splenectomy
Gynecologic Procedures: Hysterectomy, Oophorectomy, Ruptured ectopic, Laparoscopy, C-Section
Urologic Procedures: Bladder Suspension, Bladder Removed, Lithotripsy, Prostatectomy, Vasectomy

- General Procedures: Breast Biopsy, Mastectomy, Thyroid Surgery, Whipple
Heart (Cardiac) Procedures: CABG, Valve, Angioplasty, Defibrillator, Pace Maker
Vascular Procedures: Bypass Graft, Vascular Access, AAA, Thoracic Aneurysm
Thoracic Procedures: Chest Tube, Pulmonary, Pectus
Neurologic Procedures: Brain Tumor, Brain Aneurysm, Chiari Decompression, Spinal Cord Tumor, Epidural Injection, Abscess, Stent



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Orthopaedic Surgery/ Procedures

Please check any procedures you have had and give the year.

Most Recent Year

Previous Surgery Year

(if same surgery performed more than once)

Broken Bones/Fracture Repair

- Fracture Repair - Finger ----- Right Left Bilateral -----

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- Fracture Repair - Hand ----- Right Left Bilateral -----

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- Fracture Repair - Wrist ----- Right Left Bilateral -----

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- Fracture Repair - Arm ----- Right Left Bilateral -----

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- Fracture Repair - Elbow ----- Right Left Bilateral -----

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- Fracture Repair - Shoulder ----- Right Left Bilateral -----

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- Fracture Repair - Hip/Pelvis ----- Right Left Bilateral -----

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- Fracture Repair - Femur ----- Right Left Bilateral -----

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- Fracture Repair - Knee ----- Right Left Bilateral -----

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- Fracture Repair - Lower Leg ----- Right Left Bilateral -----

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- Fracture Repair - Ankle/Foot ----- Right Left Bilateral -----

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Ankle/Foot Procedures

- Ankle Arthroscopy ----- Right Left Bilateral -----

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- Ankle Fusion ----- Right Left Bilateral -----

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- Tendon Surgery ----- Right Left Bilateral -----

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- Toe Surgery specify _____ ----- Right Left Bilateral -----

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Elbow, Wrist, Hand Procedures

- Biceps Repair ----- Right Left Bilateral -----

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- Carpal Tunnel Surgery ----- Right Left Bilateral -----

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- Elbow Arthroscopy ----- Right Left Bilateral -----

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- Elbow Ligament Reconstruction ----- Right Left Bilateral -----

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- Elbow Replacement ----- Right Left Bilateral -----

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- Hand Tendon Repair ----- Right Left Bilateral -----

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- Nail Bed Surgery ----- Right Left Bilateral -----

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- Tennis Elbow Surgery ----- Right Left Bilateral -----

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- Trigger Finger Surgery ----- Right Left Bilateral -----

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- Wrist Ligament Reconstruction ----- Right Left Bilateral -----

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Knee Procedures

- Knee Arthroscopy ----- Right Left Bilateral -----

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- Cartilage surgery/meniscus surgery ----- Right Left Bilateral -----

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- Knee replacement ----- Right Left Bilateral -----

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- Ligament reconstruction - ACL ----- Right Left Bilateral -----

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- Ligament reconstruction - other ----- Right Left Bilateral -----

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Hip Procedures

- Hip replacement ----- Right Left Bilateral -----

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- AVN Surgery Core Decompression Fibular Graft Right Left Bilateral -----

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Shoulder Procedures

- Shoulder Arthroscopy ----- Right Left Bilateral -----

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- Rotator cuff surgery ----- Right Left Bilateral -----

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- Shoulder replacement ----- Right Left Bilateral -----

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- Shoulder stabilization ----- Right Left Bilateral -----

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Spine Procedures

- Laminectomy ----- Cervical Lumbar Thoracic -----

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- Anterior Fusion ----- Cervical Lumbar Thoracic -----

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- Posterior Fusion ----- Cervical Lumbar Thoracic -----

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- Posterior Discectomy ----- Cervical Lumbar Thoracic -----

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Other (List all other surgeries) _____



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Hand Dominance: Right Left Use both equally

Knee - IKDC

SYMPTOMS*

*Grade symptoms at the highest level of activity at which you think you could function without significant symptoms, even if you are not actually performing activities at this level. Check **ONLY ONE** answer for each question.

How would you rate your knee today as a percentage of normal (0% - 100%, with 100% being normal)? %

1. What is the highest level of activity that you can perform without significant knee pain?

- Very strenuous activities like jumping or pivoting as in basketball or soccer
- Strenuous activities like heavy physical work, skiing or tennis
- Moderate activities like moderate physical work, running or jogging
- Light activities like walking, housework, or yard work
- Unable to perform any of the above activities due to knee pain

2. During the past 4 weeks, or since your injury, how often have you had pain? **(PLEASE MARK A NUMBER)**

- 0 1 2 3 4 5 6 7 8 9 10
 never constant

3. During the past 4 weeks, or since your injury, how stiff or swollen was your knee?

- not at all mildly moderately very extremely

4. What is the highest level of activity you can perform without significant swelling in your knee?

- Very strenuous activities like jumping or pivoting as in basketball or soccer
- Strenuous activities like heavy physical work, skiing or tennis
- Moderate activities like moderate physical work, running or jogging
- Light activities like walking, housework, or yard work
- Unable to perform any of the above activities due to knee

5. During the past 4 weeks, or since your injury, did your knee lock or catch?

- Yes No

6. What is the highest level of activity you can perform without significant giving away in your knee?

- Very strenuous activities like jumping or pivoting as in basketball or soccer
- Strenuous activities like heavy physical work, skiing or tennis
- Moderate activities like moderate physical work, running or jogging
- Light activities like walking, housework or yard work
- Unable to perform any of the above activities due to knee



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SPORTS ACTIVITIESCheck **ONLY ONE** answer for each question

8. What is the highest level of activity you can participate in on a regular basis?

- Very strenuous activities like jumping or pivoting as in basketball or soccer
- Strenuous activities like heavy physical work, skiing or tennis
- Moderate activities like moderate physical work, running or jogging
- Light activities like walking, housework or yard work
- Unable to perform any of the above activities due to knee

9. How does your knee affect your ability to:

	<u>Not difficult at all</u>	<u>Minimally difficult</u>	<u>Moderately difficult</u>	<u>Extremely difficult</u>	<u>Unable to do so</u>
Go up stairs	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Go down stairs	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Kneel on the front of your knee	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Squat	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Sit with your knee bent	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Rise from a chair	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Run straight ahead	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Jump and land on your involved leg	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1
Stop and start quickly	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1

10. How would you rate the function of your knee on a scale of 0 to 10 with 10 being normal, excellent function and 0 being the inability to perform any of your usual daily activities?

Function **prior to** your knee injury: (PLEASE MARK A NUMBER)

0 1 2 3 4 5 6 7 8 9 10
 cannot perform daily activities No limitation

Current function of your knee: (PLEASE MARK A NUMBER)

0 1 2 3 4 5 6 7 8 9 10
 cannot perform daily activities No limitation



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SF-12 - Check ONLY ONE answer for each question

Instructions: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:

- 1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

(#2 and #3) The following items are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

- | | <u>Yes,
Limited
A Lot</u> | <u>Yes,
Limited
A Little</u> | <u>No, Not
Limited
At All</u> |
|--|-----------------------------------|--------------------------------------|---------------------------------------|
| 2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Climbing several flights of stairs | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

(#4 and #5) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 4. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 5. Were limited in the kind of work or other activities | <input type="radio"/> 1 | <input type="radio"/> 2 |

(#6 and #7) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 6. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 7. Didn't do work or perform other activities as carefully as usual | <input type="radio"/> 1 | <input type="radio"/> 2 |

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- 1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

(#9, #10 and #11) These questions are about how you feel and how things have been with you during the past 4 weeks.

For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks

- | | <u>All
of the
time</u> | <u>Most
of the
time</u> | <u>A good
bit of
time</u> | <u>Some
of the
time</u> | <u>A little
of the
time</u> | <u>None
of the
time</u> |
|---|--------------------------------|---------------------------------|-----------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| 9. Have you felt calm and peaceful? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 10. Did you have a lot of energy? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 11. Have you felt downhearted and blue? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |

12. During the past 4 weeks, how much of the time has your physical or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)?

- | <u>All
of the
time</u> | <u>Most
of the
time</u> | <u>Some
of the
time</u> | <u>A little
of the
time</u> | <u>None
of the
time</u> |
|--------------------------------|---------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |

PLEASE RETURN THIS COMPLETED PACKET TO THE FRONT DESK NOW