ROPER ST. FRANCIS
PHYSICIAN PARTNERS

Orthopaedic Surgery & Sports Medicine

New Patient Intake- Hip & Knee

Patient Name: ____
DOB: ____________________ Age: __________ Referred by: _________________________________
PCP: ______________________________________

Reason for Today's Visit:

☐ Right hip ☐ Left hip ☐ Right Knee ☐ Left Knee ☐ Bilateral Hips ☐ Bilateral Knees ☐ Other ________________

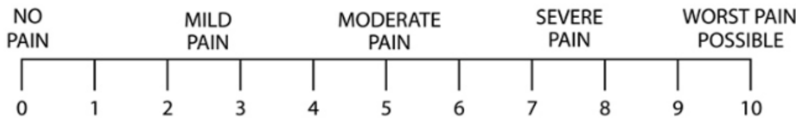
In Check one of the following:

☐ No Injury- estimated date symptoms began: ________________

☐ Injury- date of injury: ________________

If injury:
Where did the injury occur? (Circle One) Home Work School Other__________________
Is this a sports related injury? ☐ YES ☐ NO Sport: _____________________
Did you hear a "pop" when you injured your knee? ☐ Yes ☐ No
Did you experience immediate swelling? ☐ Yes ☐ No

Rate your pain on a scale of 1 to 10. (Circle Number)



Check all exacerbating factors that apply.

Climbing Stairs__ Housework__ Exercise__
Bending__ Kneeling__ Squatting__
Running__ Walking__ Sitting__
Jumping__ Laying Down__ Sudden Movements__
Donning Socks/Shoes__
Other: ____

When does it bother you the most? ________________________________

Do you have pain at night? ☐ YES ☐ NO
Does this pain cause falls or make you nervous about falling? ☐ YES ☐ NO

Check all symptoms that apply.

Numbness__ Tingling__ Stiffness__ Locking__
Swelling__ Throbbing__ Instability__ Catching__
Weakness__ Popping__ Aching__ Constant__
Sharp pains__ Shooting Pains__ Stabbing Pains__ Dull Pain__
Other: ____

Previous Treatment:

Have you had any recent imaging? ☐ YES ☐ NO
If yes, (circle one)
Type of Imaging: X Ray MRI CT
Date Performed: ____________________ Facility: ____

Have you had any previous surgical procedures to this body part for this problem? ☐ YES ☐ NO
If yes, Procedure: ____ Date: __________ Provider: ___________________

What treatments have you tried, if any? (Check all that apply)
Cortisone Injections__ Physical Therapy__ Warm Compresses__ Icing__ Cane__
Visco-Supplement Injections__ Voltaren Gel__ Orthotics__ Weight loss__ Crutch__

Have you tried any over the counter medications? (Check all that apply)
Aleve__ Advil__ Aspirin__
Tylenol__ Ibuprofen__
How often do you take these medications? _____________

Have you experienced complications with any type of anesthesia? (Check all that apply or fill in the blank)
General__ IV Sedation__ Local anesthesia__
Dental anesthesia__ Other: ________________________

Medical/Social History:

Do you have any blood relatives with osteoporosis or arthritis? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO Do you drink? ☐ YES ☐ NO
If yes, how many packs a day_______ If yes, how much in a week _______

Are you pregnant? ☐ YES ☐ NO

Allergies: Please list any additional allergies below.

Medication Name	Date Noted/Reaction

Medications: Please list any medications you are currently taking including over-the-counter medication.

Medication Name	Dosage