MAGIC VALLEY ORTHOPEDICS

Patient Label

Dr May New Patient Osteoarthritis Intake Form

What are we seeing you here for today?

☐ Right ☐ Left ☐ Bilateral ☐ Knee ☐ Hip

If both, which one is worse? ☐ Right ☐ Left

Are you right-handed or left-handed? ☐ Right ☐ Left

How long have you had joint pain? _____

Have you had previous joint replacement surgery before? ☐ Yes ☐ No

- Date of surgery: _____
- Type of joint surgery: _____
- Surgeon Name: _____
- Hospital Location: _____

Have you had any other surgery on this joint?

_____

Is there any history of trauma/injury to this joint?

_____

Have you had any previous imaging? :X-Ray, MRI, CT) ☐ Yes ☐ No

- If yes, which facility were they performed at:

_____

Have you fallen due to this condition? ☐ Yes ☐ No

What type of symptoms are you experiencing? (Check all that apply)

☐ Sharp
☐ Achy
☐ Radiating
☐ Swelling
☐ Catching
☐ Giving out
☐ Dull
☐ Burning
☐ Stiffness
☐ Locking
☐ Popping
☐ Other: _____

What aggravates the pain? (Check all that apply)

- ☐ Stairs
- ☐ Biking
- ☐ Jumping
- ☐ Walking
- ☐ Twisting/Pivoting
- ☐ Stooping/Squatting
- ☐ Running
- ☐ Other

Have you had any prior injections?

- ☐ Corticosteroid (Cortisone
- ☐ Viscosupplements (Synvisc, Monovisc, Euflexxa)

Does the pain limit your daily activities? (If yes, describe how)

_____

Do any of these decrease your pain?

• Rest	☐ Yes	☐ Minimal	☐ No
• Ice	☐ Yes	☐ Minimal	☐ No
• Heat	☐ Yes	☐ Minimal	☐ No
• OTC Meds (Aleve/Tylenol)	☐ Yes	☐ Minimal	☐ No
• Prescription Medication	☐ Yes	☐ Minimal	☐ No

Have you tried physical therapy? ☐ Yes ☐ No

How long? _____

Do you do home exercises? ☐ Yes ☐ No

Do you use any ambulatory aids/assistive devices?

☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair

How far can you walk without having pain?

- ☐ 1 step
- ☐ 10 feet
- ☐ City block
- ☐ No limit

Have you been diagnosed with Diabetes? (Type I or Type II)	☐ Yes	☐ No
Do you currently smoke or use any nicotine products?	☐ Yes	☐ No
Have you been diagnosed with Rheumatoid Arthritis?	☐ Yes	☐ No
Have you been diagnosed with blood clots? (DVT or PE)	☐ Yes	☐ No
Do you have sleep apnea or snore loudly?	☐ Yes	☐ No

What does your pain/discomfort keep you from doing that you would like to do?

_____

_____

_____