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PATIENT ENCOUNTER FORM

Patient name: _____

Chief Complaint:

1. What is the most important orthopaedic issue that you want the doctor to address today?

History of Present Illness:

2. How long ago was the problem hip or knee normal and healthy?

3. Did Single event or incident cause the onset of the problem?

4. Describe the pain or disability that you have now.

5. When is the first time you sought medical attention for this problem?

6. Have you had to change or modify your activities because of the problem?

7. Have you used a device such as a wrap, brace, cane or walker?

8. Have you taken any over the counter or prescription medications for pain or Arthritis?

9. Have you had any injections into or near the site of the painful joint?

10. Have you had any surgical procedures on the problem joint or limb?

Social History

Work Status: ☐ Employed ☐ Student ☐ Retired ☐ Disabled
☐ Homemaker ☐ Other

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Living Arrangement: ☐ House ☐ Apartment ☐ Assisted living
☐ Rent room ☐ Other_____

Are you a parent? ☐ Yes ☐ No

Number of Male Children _____ Ages _____
Number of Female Children _____ Ages _____

How many people live with you? _____

Does your home have upstairs rooms? ☐ Yes ☐ No

Do you have a person that helps with daily activities? ☐ Yes ☐ No

Do you smoke Tobacco? ☐ Yes ☐ No If yes, how much _____

Did you quit smoking in the past? ☐ Yes ☐ No If yes, when _____

How many years did you smoke before quitting? _____

Do you drink Alcohol? ☐ Never ☐ Rarely ☐ Socially ☐ Heavily

Do you have any history of serious problems with alcohol, prescription or non prescription drugs?

☐ No history of drug or alcohol problems
☐ Previous treatment for drug or alcohol problems
☐ Currently under treatment for drugs or alcohol use
☐ Clean & Sober since _____

Goals of Treatment

If you were not limited by your hip or knee condition what activities would you like to do or do better than you can now?

Daily Activities:

_____
_____
_____
_____
_____
_____
_____
_____

Work Activities:

_____
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_____

Recreation/Sports:

_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature:_____ **Date/Time:**_____

FOR PHYSICIAN USE ONLY

Physical Exam

Ht _____ Wt _____

General Appearance/Gait

_____

_____

_____

Spine Deformity/Pelvic Tilt ☐ Yes ☐ No

_____

Leg Length Discrepancy ☐ Yes ☐ No

Right or Left side/longer by _____cm

Difficult to evaluate _____

Muscle Mass/Atrophy

_____

Right Hip Exam:

Supine Internal Rotation _____ Supine External Rotation _____

90° Flexed Internal Rotation_____90° Flexed External Rotation _____

Maximum Flexion _____Maximum Abduction _____

FOR PHYSICIAN USE ONLY

Right Knee Examination:

Skin & Incisions _____

Swelling/Effusion _____

Alignment _____

Range of Motion _____

Ligament Stability _____

_____

Vascular Color/Warmth _____

Neurologic Motor/Sensation:

Straight leg raise _____ Ankle Plantar/Dorsiflexion _____

Reflexes _____

Left Hip Exam:

Supine Internal Rotation _____ Supine External Rotation _____

90° Flexed Internal Rotation_____90° Flexed External Rotation _____

Maximum Flexion _____Maximum Abduction _____

FOR PHYSICIAN USE ONLY

Left Knee Examination:

Skin & Incisions _____

Swelling/Effusion _____

Alignment _____

Range of Motion _____

Ligament Stability _____

_____

Vascular Color/Warmth _____

Neurologic Motor/Sensation:

Straight leg raise _____Ankle Plantar/Dorsiflexion_____

Reflexes _____

Radiographs & Studies:

AP/Pelvis _____

Lateral Hip _____

A/P Both Knees _____

Lateral Knees _____

Sunrise View_____

FOR PHYSICIAN USE ONLY

Special Studies:

_____
_____
_____
_____

Assessment/Plan or Discussion

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