



UNIVERSITY OF SOUTHERN CALIFORNIA  
ORTHOPAEDIC SURGERY ASSOCIATES

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FOR OFFICE USE  
 Transcribed

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PROFESSOR OF  
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CHIEF OF SPORTS MEDICINE

INITIAL KNEE CONSULTATION

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_  
SEX: MALE FEMALE HAND DOMINANCE: RIGHT LEFT  
HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SOCIAL SECURITY NO: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
INSURANCE: \_\_\_\_\_ POLICY NO: \_\_\_\_\_  
REFERRED BY: \_\_\_\_\_ PHONE NO: \_\_\_\_\_  
HOSPITAL/ ADDRESS: \_\_\_\_\_

Which knee:  Right  Left

Date of onset OR length of symptoms: \_\_\_\_\_

Prior injuries to this knee:  YES  NO

If yes, please describe: \_\_\_\_\_

Please describe how your symptoms began (traumatic/injury OR gradual/unknown onset): \_\_\_\_\_

Location of pain:  front of knee  inner knee  outer knee  all over

If 100% were normal, as of today what percentage would you give your knee as a grade? \_\_\_\_\_

Pain at rest (1 least - 10 greatest) \_\_\_\_\_

Pain with activity (scale 1-10) \_\_\_\_\_

Pain at night  YES  NO

Activities that make the pain better: \_\_\_\_\_

Activities that make the pain worse: \_\_\_\_\_

Swelling  YES  NO

Type of Pain:  Sharp  Dull  Throbbing  Numbness  
 Shooting  Burning  Tingling

Nature of Pain:  Constant  Frequent  Occasional  Intermittent

Since onset, is the pain getting:  Better  Worse

Does the pain radiate?  Yes  No

If yes, where:  Groin  Back  Hip  Thigh  Calf  Foot

Symptoms are worse in:  Morning  Afternoon  Night  Same all day

Any mechanical symptoms:  None  Popping  Clicking  Locking  Giving way  Instability

Do you feel that you limp:  No limp  Slight  Moderate  Severe

Do you use assistive devices:  None  Cane  Crutches  Walker  Wheelchair

How far can you walk before limited by pain:  Unlimited  Indoor only  Less than 2 blocks  
 2-10 blocks  More than 10 blocks (30 minutes)  Unable to walk

Difficulty with stairs:  None  Normal going up, difficult going down  One at a time  
 Need to hold banister  Unable to walk up stairs

Can you sit comfortably:  Unlimited  Less than 1 hour  Severe discomfort  
 Discomfort arising from chair

Have you seen anyone for this problem  Yes  No  
If yes, who:  Family doctor  Orthopaedic Surgeon  Therapist  Other: \_\_\_\_\_  
Name, Location, Phone \_\_\_\_\_  
Type of Treatment \_\_\_\_\_

Did your symptoms improve after:  Yes  No  
Please describe: \_\_\_\_\_

Please describe your hobbies/ activities: \_\_\_\_\_

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### REVIEW OF SYSTEMS

#### HEENT (Head, Ears, Eyes, Nose, and Throat):

- Normal  Headaches  Glaucoma  
 Cataracts  Dental Problems  Sinusitis

#### PULMONARY (Lungs):

- Normal  Asthma  COPD  Shortness of Breath

#### CARDIOVASCULAR (Heart):

- Normal  Chest Pain  Palpitations  Previous Heart Surgery  Abnormal rhythm

#### NEUROLOGIC:

- Normal  Stroke  Seizure  Headaches  Motor/Sensory Deficit

#### GASTROINTESTINAL:

- Normal  Stomach pain with NSAIDs (Motrin, Ibuprofen)  Ulcer

#### Heartburn

- GI/Rectal Bleed  Adverse reaction to NSAIDs: \_\_\_\_\_

#### GENITOURINARY:

- Normal  Frequent night-time urination  Prostate  
 Incontinence  Burning with urination

#### SKIN:

- Normal  Skin rash  Psoriasis

#### MUSCULOSKELETAL

- Normal except shoulder  Other joint pains: location \_\_\_\_\_

PAST MEDICAL HISTORY

Please list any Medical Illnesses (i.e. diabetes, high blood pressure, etc...)

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

List any prior surgeries

Type of Surgery	Year	Hospital – Surgeon
1. _____		
2. _____		
3. _____		
4. _____		

List any allergies to medications

Medication	Side Effect
1. _____	
2. _____	
3. _____	

List current medications being taken on a regular basis (include dose and how often)

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_

FAMILY HISTORY

Father  Living Any medical problems: \_\_\_\_\_  
 Deceased – at age \_\_\_\_\_ Cause: \_\_\_\_\_  
Mother  Living Any medical problems: \_\_\_\_\_  
 Deceased – at age \_\_\_\_\_ Cause: \_\_\_\_\_  
Siblings: Number \_\_\_\_\_ Any medical problems: \_\_\_\_\_

SOCIAL HISTORY

Marital Status:  Married  Single  Divorced  
Number of children: \_\_\_\_\_  
Do you smoke?  No  Yes – If so how many packs per day: \_\_\_\_\_  
Do you drink alcohol?  No  Occasionally  Daily

Employment

Type of work: \_\_\_\_\_  
Currently working:  Yes  No  
If not working:  
Are you  temporarily unemployed  off work – how long \_\_\_\_\_  
Any heavy lifting involved with work:  Yes  No

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

\_\_\_\_\_  
Signature of Patient or Parent of Minor                      Date                      Reviewed by MD (physician signature)

(TO BE COMPLETED BY MD)

KNEE MUSCULOSKELETAL EXAM

CONSTITUTIONAL (General Appearance of the patient)

Normal (WD/WN)  Abnormal \_\_\_\_\_

PSYCHIATRIC  Normal (Alert/Oriented x 3)  Abnormal \_\_\_\_\_

HEENT  Normal (AT/NC, EOMI)  Abnormal \_\_\_\_\_

LYMPHATIC  Normal (no lymphadenopathy)  Abnormal \_\_\_\_\_

SKIN  Normal (no ulcers/ lesion, incisions as described in Extremity exam)  
 Abnormal \_\_\_\_\_

CARDIOVASCULAR

Peripheral vascular system

Observation:  Normal  Swelling  Varicosities

Palpation:

Pulses DP  1+  2+  non-palp PT  1+  2+  non-palp

Temperature  warm  cool

Edema  none  1+  2+ pitting

NEUROLOGIC

Deep tendon reflexes

Knee  1+  2+  hyper-reflexic  absent

Achilles  1+  2+  hyper-reflexic  absent

Sensation

Normal  Abnormal \_\_\_\_\_

RIGHT KNEE

- Inspection  normal  arthroscopy incisions  
 arthrotomy incision  atrophy  
 effusion (none / mild / mod)
- Palpation  
 TTP:  none  arthrotomy incision  
 arthroscopy portals  
 Joint line  medial  lateral  anterior  
 posterior
- ROM  normal (0-140)  
 abnormal \_\_\_\_\_
- Stability  
 Lachman  negative  1+  2+  
 Anterior drawer  negative  1+  2+  
 Posterior drawer  negative  1+  2+  
 Pivot shift test  negative  slide  clunk  
 Dial test  incr ER @ 0° \_\_\_\_\_ / 30° \_\_\_\_\_  
 Recurvatum  negative  present \_\_\_\_\_  
 Valgus instability  negative  @ 0° \_\_\_\_\_ / 30° \_\_\_\_\_  
 Varus instability  negative  @ 0° \_\_\_\_\_ / 30° \_\_\_\_\_
- McMurray's  normal  medial  lateral
- Muscle strength  normal  quadriceps weakness
- Tone  normal  spasticity
- Patella  
 TTP:  none  inferior pole  superior pole  
 medial facet  lateral facet  
 medial retinaculum  lateral retinaculum  
 Compression Pain  none  present  
 Apprehension  none  medial  lateral  
 Crepitus  No  Yes
- Gait  Normal  Antalgic  
 Thrust  No  Yes Valgus /  Varus
- Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

LEFT KNEE

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NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

KNEE FOLLOW-UP [ ] Right Knee [ ] Left Knee

Since your last visit:

Is Dr. Vangness prescribing any medication for you at this time? [ ] Yes [ ] No
If yes, what medicine: \_\_\_\_\_

1. What treatments have you had? [ ] None [ ] Medications [ ] Injection [ ] Physical Therapy [ ] Surgery
Please describe: \_\_\_\_\_

2. Do you feel your symptoms have improved? YES NO
Please describe: \_\_\_\_\_

If 100% were normal, as of today what percentage would you give your knee as a grade? \_\_\_\_\_

Location of pain: [ ] front of knee [ ] inner knee [ ] outer knee [ ] all over

Pain at rest (1 least - 10 greatest) \_\_\_\_\_

Pain with activity (scale 1-10) \_\_\_\_\_

Pain at night [ ] YES [ ] NO

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Swelling [ ] YES [ ] NO

Type of Pain: [ ] Sharp [ ] Dull [ ] Throbbing [ ] Numbness [ ] Shooting [ ] Burning [ ] Tingling

Nature of Pain: [ ] Constant [ ] Frequent [ ] Occasional [ ] Intermittent

Does the pain radiate? [ ] Yes [ ] No

If yes, where: [ ] Groin [ ] Back [ ] Hip [ ] Thigh [ ] Calf [ ] Foot

Symptoms are worse in: [ ] Morning [ ] Afternoon [ ] Night [ ] Same all day

Any mechanical symptoms: [ ] None [ ] Popping [ ] Clicking [ ] Locking [ ] Giving way [ ] Instability

Do you feel that you limp: [ ] No limp [ ] Slight [ ] Moderate [ ] Severe

Do you use assistive devices: [ ] None [ ] Cane [ ] Crutches [ ] Walker [ ] Wheelchair

How far can you walk before limited by pain: [ ] Unlimited [ ] Indoor only [ ] Less than 2 blocks
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[ ] Need to hold banister [ ] Unable to walk up stairs

Can you sit comfortably: [ ] Unlimited [ ] Less than 1 hour [ ] Severe discomfort [ ] Discomfort arising from chair

SOCIAL HISTORY

Employment

Type of work: \_\_\_\_\_

Currently working: [ ] Yes [ ] No

Limitations: [ ] None [ ] Limited work [ ] Disabled

If not working:

Are you [ ] Temporarily Unemployed [ ] Disabled - How long \_\_\_\_\_

Any heavy lifting involved with work: [ ] Yes [ ] No

REVIEW OF SYSTEMS

CONSTITUTIONAL:

Any recent:  Fevers  Chills  Nausea  Vomiting  None

GASTROINTESTINAL:

- Normal  Stomach pain with NSAIDs (Motrin, Ibuprofen)
- Ulcer  Heartburn
- GI/Rectal Bleed  Adverse reaction to NSAIDs

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