DFW Neuropathy

New Knee Patient Questionnaire Form

6210 Campbell Road St 100
Dallas TX 75248

466 Mid Cities Blvd
Hurst TX 76054

919 W Randol Mill Rd
Arlington TX 76012

Name: ____________________________
Date: ____________________________
Time: ____________________________
PCP: ____________________________
PCP number:____________________________
Referred by: ____________________________

CHIEF COMPLAINT: What are you here to see the doctor for? ______________________________________

TIMING OF PAIN/ ALLEVIATING AND AGGRAVATING FACTORS

When did you first notice pain or problems with the knees? ____

What were the symptoms (pain, numbness, popping, etc,) ____

When did this current pain begin? ____

What kinds of things make your pain feel better?____

What kinds of things make your pain feel worse? ____

DURATION OF PAIN

How long have you had the pain problem you are currently experiencing (in months and years)? ___________________

What caused your current pain to start? ____

How often do you have your pain?

____a. Constantly (80-100% of time)　　____c. Intermittently (25-81% of time)

____b. Nearly constant (50-80% of time)　　____d. Occasionally (less than 25% of time

Past Treatment	Did it give you relief? For how long?	When and why did you discontinue?

MEDICATIONS: Please provide our office with a list of any and all medications, dosages, how many times per day and for how long you have been taking them. Your physician will go over this list with you.

Please circle **YES** or NO to the following questions. This will aid us in completing your medical history.

1. Do your knees crack, pop, or give you pain? □ Yes □ No – Details ________________________________
2. Do you suffer from weakness in your back or neck? □ Yes □ No – Details ________________________________
3. Do you have weakness in your in your arms or hands? □ Yes □ No – Details ________________________________
4. Do you suffer from burning in your legs or feet? □ Yes □ No – Details ________________________________
5. Do your legs or knees buckle or ever give away? □ Yes □ No – Details ________________________________
6. Have you ever had any knee injections? □ Yes □ No – How often________________________________
7. Have you ever had any knee surgery? □ Yes □ No – How often________________________________
8. Do you frequently trip or catch your toe when walking? □ Yes □ No – Details ________________________________

9. Have you ever been diagnosed with Arthritis? □ Yes □ No – Details ______________________________

10. Do you ever suffer from dizziness? □ Yes □ No – Details ______________________________

11. Do you have difficulty maintaining your balance? □ Yes □ No – Details ______________________________

12. Do you frequently trip or catch your toe when walking? □ Yes □ No – Details ______________________________

Scarlet Fever	Yes	No	Diabetes	Yes	No	Skin Disorders	Yes	No
Measles	Yes	No	High Blood Pressure	Yes	No	Tumor, Cancer, Cysts	Yes	No
German Measles	Yes	No	High cholesterol	Yes	No	Venereal Diseases	Yes	No
Rheumatic Fever	Yes	No	Dizziness/Fainting	Yes	No	HIV +	Yes	No
Mumps	Yes	No	Weakness/Paralysis	Yes	No	Hepatitis	Yes	No
Chicken Pox	Yes	No	Insomnia	Yes	No	Problems with Urination	Yes	No
Malaria	Yes	No	Frequent Anxiety or	Yes	No	**FEMALES ONLY**		
Tuberculosis	Yes	No	Depression	Yes	No	No. Of Pregnancies	Yes	No
Gum or Tooth Problems	Yes	No	Recurrent Headaches	Yes	No	Irregular Periods	Yes	No
Sinusitis	Yes	No	Recurrent Colds	Yes	No	Severe Cramps	Yes	No
Eye Trouble	Yes	No	Gallbladder Disease	Yes	No	Excessive flow	Yes	No
Ear, Nose, Throat	Yes	No	Bloody Stools	Yes	No	**IMMUNIZATIONS**		
Head Injury	Yes	No	Recurrent Diarrhea	Yes	No	MMR-Measles/Mumps	Yes	No
Hay Fever/Allergies	Yes	No	Jaundice/Hepatitis	Yes	No	Polio	Yes	No
Asthma	Yes	No	Stomach Problems/Ulcers	Yes	No	DPT	Yes	No
Shortness of Breath	Yes	No	Recent Weight Gain or loss	Yes	No	Tetanus	Yes	No
Emphysema	Yes	No	Joint Disease	Yes	No	Flu Shot	Yes	No
Chest Pain/Pressure	Yes	No	Back Problems	Yes	No	Pneumovax	Yes	No
Chronic Cough	Yes	No	Sciatica	Yes	No	Mammogram	Yes	No
Rapid Heart Beat	Yes	No	Neck Pain	Yes	No	Flexible Sigmoidoscopy	Yes	No
Heart murmur	Yes	No	Do you take any blood thinners	Yes	No	Colonoscopy, rectal Exam	Yes	No

1) List Hospitalizations & Surgery Dates: (Exact dates are not necessary; your doctor will discuss this with you).

Hospitalizations	Dates	Surgeries	

2) Do you smoke, or have you ever smoked? Y N

a. If so, how much? _____cig/day, ____packs/day, and for how long? _____months, ____years

b. If you quit, when? ____ how much? ___cig/day, ___packs/day, for how long? ___months, ___years

c. Any significant alcohol use? ____Y ____N Any Illicit Drug use? ____Y ____N

FAMILY MEDICAL HISTORY:

3) Father: ________________________________Alive? _____ State of Health______________________

Deceased? ____Age at Death _____ Cause of Death:____

4) Mother: ________________________________Alive? _____ State of Health______________________

Deceased? ____Age at Death _____ Cause of Death:____

____________________________________ ________________________

Patient Signature Date

Hyalgan Osteoarthritis Knee Treatment Program

Medical Necessity and Prescription –Initial

Patient Name __________________________ Date of Birth: ________________ Date: ______________

Please complete the following information about your knee(s) pain/stiffness:

Circle the number that best describes how your pain has interfered with your:

a. a. **Walking ability:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

b. **Sitting:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

c. **Standing:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

d. **Normal Daily Activities:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

e. **Mood:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

f. **Normal Work (includes both work outside the home and housework):**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

g. **Sleep:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

h. **Family Relationship:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

i. **Relationship with your spouse/partner:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

j. **Social activities with other people:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

k. **Enjoyment of life:**

Does not Interfere-0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

Meaning = Impairment score: 0-20 = Mild; 21-40 = Moderate; 41-60 = Severe; 61-100 = Very severe

INITIAL TREATMENT GOALS: Please list specific goals you would like to achieve by your treatment.

Example: Return to previous employment, to be able to play golf, to be able to walk my dog, to be able to dress myself, etc.

Comments:____

Stop here – Please turn your paper(s) into a staff member.