Name:
DOB:
Chart:
Age/Gender:
Date:

INITIAL ORTHOPEDIC EVALUATION - ROBERT KLENCK, MD

HOME ADDRESS: _____

EMAIL ADDRESS: _____ PREFERRED PHONE#: _____

PRIMARY CARE PHYSICIAN: _____ PHARMACY: _____

INSURANCE/ PRIMARY SUBSCRIBER: _____

INVOLVED JOINT(S): (circle all that apply):

Low back / SI joint: Right / Left Height: _____ Weight: _____

Hip: Right / Left

Knee: Right / Left

When did you FIRST notice the pain? _____

If it is progressing, is it progressing Rapidly or Slowly? R / S

Is there a family history of similar problem(s)? Y / N

Do your legs feel to be the same length? Y / N

Is there radiation of pain down the leg to the knee? Y / N

Past the knee? Y / N

Minimum pain on a scale of 0 to 10: _____

Maximum pain on a scale of 0 to 10: _____

Do you have pain at rest? Y / N

Limp / gait disturbance? Y / N

Balance problems? Y / N Falls / Near Falls: Y / N

Walking aids: Wheelchair / Walker / Crutch(es) / Cane / Brace / Sleeve

Is this affecting your activities of daily living? If yes, describe which:

Stairs / Bathing / Cooking / Other: _____

Pain is aggravated by: (circle all that apply):

Sitting / Driving / Walking / Turning / Sports: _____ / Other: _____

Pain upon arising up from sitting / Night pain / Affecting sleep

Do you have difficulty donning or doffing footwear / or performing foot care? Y / N

Name:
DOB:

Does the pain improve after "warming the joint up?" Y / N

Does the pain worsen throughout the day? Y / N

Does this condition affect your ability to exercise / lose weight? Y / N

Do you feel deconditioned? Y / N

Distance / Time that you are able to walk without significant pain:

Previous treatments: (circle all that apply):

Rest / Activity modifications / Muscle relaxants

Pain/narcotic medications / Creams/rubs

Other treatments: Acupuncture / Chiropractic / Physical Therapy

"Cortisone" injection(s) / "Gel" injections / Prolotherapy / PRP / Stem cell injections

My current regimen is controlling my pain: Y / N

PAST MEDICAL HISTORY:

CURRENT MEDICATIONS: (INCLUDE HERBS/VITAMINS, AND BLOOD THINNERS):

MEDICATIONS AND FOOD ALLERGIES:

Name:
DOB:

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING PROBLEMS (CIRCLE AND DESCRIBE)

HEAD: STROKE / TIA / SEIZURES / EYES / EARS / NOSE / THROAT / THYROID

GI: ESOPHAGUS / GERD / REFLUX / STOMACH / ULCERS / DIGESTIVE

LUNGS: BREATHING PROBLEMS / ASTHMA / SLEEP APNEA / CPAP

HEART: CONGESTIVE HEART FAILURE / HEART ATTACK / STENTS / IRREGULAR HEART BEAT

LIVER / CIRRHOSIS / HEPATITIS: TYPE: A / B / C

KIDNEY DISEASE / STONES

BLADDER / URINATION

BOWEL PROBLEMS

GENERAL: HYPERTENSION / OBESITY / DIABETES

HYPOTHYROIDISM / HORMONE PROBLEMS

CIRCULATION PROBLEMS / LEG SWELLING / RASH / OPEN WOUND

BLEEDING PROBLEMS / BLOOD CLOTS / PULMONARY EMBOLI

CANCER - TYPE: _____

NUMBNESS / TINGLING / BALANCE PROBLEMS

PSYCHOLOGICAL CONDITIONS / DRUG ADDICTION

PAST SURGICAL HISTORY:

PLEASE LIST ALL SURGERIES AND APPROXIMATE DATES or AGE AT TIME OF SURGERY:

Name:
DOB:

FAMILY HISTORY:

MOTHER: ALIVE / DECEASED
MEDICAL PROBLEMS / CAUSE OF DEATH: _____

FATHER: ALIVE / DECEASED
MEDICAL PROBLEMS / CAUSE OF DEATH: _____

SISTER: ALIVE / DECEASED
MEDICAL PROBLEMS / CAUSE OF DEATH: _____

SISTER: ALIVE / DECEASED
MEDICAL PROBLEMS / CAUSE OF DEATH: _____

SISTER: ALIVE / DECEASED
MEDICAL PROBLEMS / CAUSE OF DEATH: _____

BROTHER: ALIVE / DECEASED
MEDICAL PROBLEMS / CAUSE OF DEATH: _____

BROTHER: ALIVE / DECEASED
MEDICAL PROBLEMS / CAUSE OF DEATH: _____

BROTHER: ALIVE / DECEASED
MEDICAL PROBLEMS / CAUSE OF DEATH: _____

SOCIAL HISTORY:

OCCUPATION: _____ RETIRED: Y / N

STATUS: SINGLE / MARRIED / DIVORCED / SEPARATED / WIDOWED

SMOKER? Y / N / FORMER SMOKER AMOUNT: _____

ALCOHOL: SOCIAL / LIGHT / HEAVY

RECREATIONAL DRUGS: Y / N - IF YES, TYPE: _____

DO YOU LIVE ALONE: Y / N

DO YOU HAVE SOMEONE WHO CAN ASSIST YOU AT HOME?

IF SO, WHO, AND WHAT IS THEIR RELATION TO YOU?

HOW MANY STEPS LEAD UP TO YOUR RESIDENCE:

RESIDENCE IS: SINGLE STORY / TWO-STORY / MULTI-LEVEL

ARE YOU INVOLVED WITH LITIGATION RELATED TO THIS PROBLEM? Y / N