

Richard L. Wixson, M.D --- Hip & Knee Form

Name: _____ Date: _____

Current Age: _____ Height: _____ Weight: _____

1. For what reason are you here? _____

2. How long have you had this problem? _____

3. Please rate your pain on a scale from 1 – 10 (1 = Minimal ... 10 = Severe Pain) 0 () = None

1 () 2 () 3 () 4 () 5 () 6 () 7 () 8 () 9 () 10 ()

4. What is the level of pain in each of the joints listed below? (Please mark one answer for each)

Pain Scale	None	Slight or Occasional	Mild with Stairs	Mild with Walking	Moderate	Marked or Severe	Disabling
Right Hip	()	()	()	()	()	()	()
Left Hip	()	()	()	()	()	()	()
Right Knee	()	()	()	()	()	()	()
Left Knee	()	()	()	()	()	()	()
Back	()	()	()	()	()	()	()

5. Where are you having pain? (Check all that apply)

Location	Right Hip	Left Hip	Location	Right Knee	Left Knee
None	()	()	None	()	()
Groin	()	()	Front (Under kneecap)	()	()
Thigh	()	()	Inside (Close to other knee)	()	()
Side	()	()	Outside (Away from other knee)	()	()
Buttock	()	()	Back of Knee	()	()
Knee	()	()	Generalized	()	()

6. Do you use support when you walk?

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Two Canes |
| <input type="checkbox"/> Cane, Lone Walks Only | <input type="checkbox"/> Two Crutches |
| <input type="checkbox"/> Cane, Most of the Time | <input type="checkbox"/> Walker |
| <input type="checkbox"/> One Crutch | <input type="checkbox"/> Not Able to Walk |

7. How Far Are You Able to Walk?

- | | |
|---|--|
| <input type="checkbox"/> Unlimited Distance | <input type="checkbox"/> 1-3 Blocks |
| <input type="checkbox"/> Greater than 10 Blocks | <input type="checkbox"/> Less than One Block |
| <input type="checkbox"/> 5-10 Blocks | <input type="checkbox"/> Indoors Only |
| <input type="checkbox"/> 3-5 Blocks | <input type="checkbox"/> Bed/Chair Transfer Only |

Richard L. Wixson, M.D --- Hip & Knee Form

8. Do You Have Difficulty with Stairs

Going Down (Descending)

- None/Normal
- Mild/Railing
- Moderate/One Step at Time
- Extreme/Any Method
- Unable

Going Up (Ascending)

- None/Normal
- Mild/Railing
- Moderate/One Step at Time
- Extreme/Any Method
- Unable

9. Do you have difficulty putting on shoes and socks?

Right

- None
- Some
- Very difficult
- Unable

Left

- None
- Some
- Very difficult
- Unable

Please answer the additional questions below if you are a new patient or have a new joint problem

10. What medications have you used for your pain? (Check all)

- | | | |
|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Ibuprofen (Motrin/Advil) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Celebrex | <input type="checkbox"/> Naproxen (Aleve) |
| <input type="checkbox"/> Toradol/Tramadol | <input type="checkbox"/> Norco/Vicodan | <input type="checkbox"/> Other _____ |

11. Have you had injections into your joint?

- | | Did it Help? | How Many | When? |
|---|--|----------|-------|
| <input type="checkbox"/> None | | | |
| <input type="checkbox"/> Steroids | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Synvisc (Hylan)
Hyalgan, etc. | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |

12. Have you had physical therapy or exercise training for you joint?

- | | Did it Help? | How Long | When? |
|--|--|----------|-------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |