Mark M. Dolan, 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. 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	( )	( )	( )	( )	( )	( )	( )

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

Location	Right Hip	Left Hip
None	( )	( )
Groin	( )	( )
Thigh	( )	( )
Side	( )	( )
Buttock	( )	( )
Knee	( )	( )

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

5. Is your pain ( ) Getting Worse? ( ) Getting Better? ( ) Staying the Same?
6. Is your pain ( ) Intermittent? ( ) Constant?
7. How would you describe your pain?
   ( ) Sharp ( ) Dull ( ) Throbbing ( ) Tight ( ) Burning ( ) Tingling
8. How much pain do you have with each activity? (Please mark one answer for each)

Pain Scale		None	Mild	Moderate	Severe	Extreme
Walking on a flat surface	Right	( )	( )	( )	( )	( )
	Left	( )	( )	( )	( )	( )
Going up or down stairs	Right	( )	( )	( )	( )	( )
	Left	( )	( )	( )	( )	( )
At night while in bed	Right	( )	( )	( )	( )	( )
	Left	( )	( )	( )	( )	( )
Sitting or Lying	Right	( )	( )	( )	( )	( )
	Left	( )	( )	( )	( )	( )
Standing upright	Right	( )	( )	( )	( )	( )
	Left	( )	( )	( )	( )	( )

9. Rate your pain on a scale from 1 – 10 (1 = Minimal … 10 = Severe Pain)

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

10. What degree of difficulty do you have with each of these activities? (Please mark one for each)

Difficulty		None	Mild	Moderate	Severe	Extreme
Going shopping		( )	( )	( )	( )	( )
Rising from Bed		( )	( )	( )	( )	( )
Rising from Sitting		( )	( )	( )	( )	( )
Standing		( )	( )	( )	( )	( )
Bending to Floor		( )	( )	( )	( )	( )
Walking on Flat Surfaces		( )	( )	( )	( )	( )
Getting In/Out of Car		( )	( )	( )	( )	( )
Lying in Bed		( )	( )	( )	( )	( )
Getting In/Out of Bath/Shower		( )	( )	( )	( )	( )
Sitting		( )	( )	( )	( )	( )
Getting on/off toilet		( )	( )	( )	( )	( )
Heavy domestic duties		( )	( )	( )	( )	( )
Light domestic duties		( )	( )	( )	( )	( )
Taking off socks/shoes	Right	( )	( )	( )	( )	( )
	Left	( )	( )	( )	( )	( )
Putting on socks/shoes	Right	( )	( )	( )	( )	( )
	Left	( )	( )	( )	( )	( )
How severe is your stiffness after first wakening in the morning?						
	Right	( )	( )	( )	( )	( )
	Left	( )	( )	( )	( )	( )
How severe is your stiffness after sitting, lying or resting later in the day?						
	Right	( )	( )	( )	( )	( )
	Left	( )	( )	( )	( )	( )
How much swelling do you appear to have?						
	Right	( )	( )	( )	( )	( )
	Left	( )	( )	( )	( )	( )
Do you have a limp?	Right	( )	( )	( )	( )	
	Left	( )	( )	( )	( )	

11. Do you use support when you walk?

( ) None
( ) Cane, Lone Walks Only
( ) Cane, Most of the Time
( ) One Crutch
( ) Two Canes
( ) Two Crutches
( ) Walker
( ) Not Able to Walk

12. How Far Are You Able to Walk?

( ) Unlimited Distance
( ) Greater than10 Blocks
( ) 5-10 Blocks
( ) 3-5 Blocks
( ) 1-3 Blocks
( ) Less than One Block
( ) Indoors Only
( ) Bed/Chair Transfer Only

13. 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

14. Are you able to use public transportation if you needed to?
( ) Able to enter ( ) Unable to enter ( ) Do not use public transportation

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

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

( ) None	( ) Tylenol	( ) Ibuprofen (Motrin/Advil)
( ) Aspirin	( ) Celebrex	( ) Naproxen (Aleve)
( ) Toradol/Tramadol	( ) Norco/Vicodan	( ) Other _____

16. Have you had injections into your joint?

	Did it Help?	How Many	When?
( ) Steroids	( ) Yes ( ) No	_____	_____
( ) Synvisc (Hylan) Hyalgan, etc.	( ) Yes ( ) No	_____	_____

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

	Did it Help?	How Long	When?
( ) Yes ( ) No	( ) Yes ( ) No	_____	_____