Texas Institute for Hip & Knee Surgery
www.texashipandknee.com

Orthopaedic Specialists of Austin

Patient Name: ____________________________ Date Of Birth: _____________________________

What are you being seen for today?

☐ Knee ☐ Hip

Which side is hurting you?

☐ Right ☐ Left ☐ Both

How long have you had pain?

☐ 0-1 years ☐ 1-3 years ☐ 3-5 years ☐ 5-10 years ☐ > 10 years

How has the pain affected your daily life? (Check all that apply)

☐ Difficulty going up and down stairs
☐ Difficulty getting in and out of car
☐ Unable to walk more than 5 blocks
☐ Pain keeps awake at night
☐ Worried might fall
☐ Have fallen due to knee/hip
☐ Other: ___________________
____

**Have you been taking any medication (over the counter or prescribed) for the pain?
Please complete all sections:**

Medication	Amount taken at a time	How often	Date medication was started	Has it helped?

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What else have you tried? Check all that apply and please be specific. List dates when applicable. If treatments were provided by another doctor include the doctors' name (records from previous treating doctors will need to be provided to the office).

☐ Cane/Walker/Crutches (start of use date) _______________________________________
☐ Physical therapy (where? Length of treatment)__________________________________
____
☐ Steroid Injections (dates and doctor)____
____
☐ Supartz, Synvisc, Orthovisc, Euflexxa, and/or Hyalagan Injections (date and doctor) ___
____
☐ Brace (type and start date) ____
☐ Weight Loss (if applicable) ____
☐ Home Exercise Program (start and end date) ___________________________________

____
Patient Signature Date