TuftsMedicine
Tufts Medical Center

Department of Orthopaedics

NEW PATIENT JOINT EVALUATION FORM

Name: _____ Phone Number: _____

Height: _____ feet _____ inches Weight: _____ lbs Age: _____

Reason for today's visit:

Hip: ☐ Right ☐ Left ☐ Bilateral **Knee:** ☐ Right ☐ Left ☐ Bilateral

Tell us about your symptoms:

1. How long have the symptoms been bothering you? _____

   _____

2. Any injury or event that caused the pain? _____

   _____

3. How much pain do you experience with activity? ☐ Mild ☐ Moderate ☐ Severe

4. Please describe the quality of the pain (examples: aching, throbbing, sharp, shooting):

   _____

5. What makes the pain worse? (check all that apply)

   ☐ Walking ☐ Uneven surfaces ☐ Going up stairs ☐ Going down stairs

   ☐ Rising from a seated postition ☐ Deep knee bending

   ☐ Other (please specify): _____

6. Does the pain wake you up at night? ☐ Yes ☐ No

7. Other symptoms? (examples: locking, instability) _____

   _____

PRIOR TREATMENTS PLEASE INDICATE ALL THAT APPLY	
☐ Changes in activity	☐ NSAIDs (ibuprofen, naproxen, Aleve, Motrin, etc.)
☐ Weight loss	☐ Narcotic medication (examples: Oxycodone, Methadone)
☐ Home exercise	☐ Physical therapy – if yes, how long?
☐ Braces	☐ Steroid injections – if yes, date of last injection:
☐ Walking aids	☐ Viscosupplementation (gel) injections – if yes, date of last injection:
☐ Acetaminophen/Tylenol	☐ Other:
☐ Prior surgeries:	

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SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Living Status: ☐ Alone ☐ With Family ☐ Rehab ☐ Other: _____

Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Occupation: _____

Smoker: ☐ Yes ☐ No ☐ Formerly If yes, how many packs per day? _____ # of years? _____

Alcohol: ☐ Yes ☐ No ☐ Formerly If yes, how many drinks per week? _____

Recreational Drug Use: ☐ Yes ☐ No If yes, how much and how often? _____

FAMILY HISTORY

PLEASE INDICATE ANY OF THE FOLLOWING THAT APPLY TO YOUR FAMILY

Mother (M), Father (F), Siblings (S), Other (O)

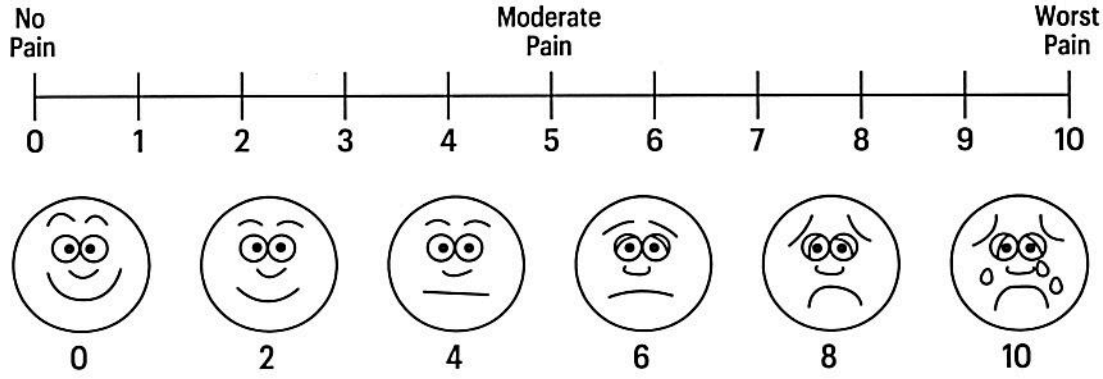
	M	F	S	O		M	F	S	O		M	F	S	O
Arthritis					Diabetes					Migraine				
Bleeding Disorder					Kidney Disease					Osteoporosis				
Blood Clot					Gout					Stroke				
Deep Vein Thrombosis					Heart Disease					Thyroid				
Pulmonary Embolism					Hypertension									
Cancer					Liver Disease									

REVIEW OF SYSTEMS

PLEASE INDICATE ANY OF THE FOLLOWING THAT APPLY TO YOU

☐ Eyes (loss of vision)	☐ Numbness / Tingling	☐ Dental Problems
☐ Ear, Nose, Throat	☐ Anxiety / Depression	☐ Joint / Muscle Pains / Cramps
☐ Digestion, Stomach, Bowel	☐ Fever / Chills / Fatigue	☐ Blackout/Fainting
☐ Bladder Problems	☐ Chest Pain / Tightness	☐ Open/ Draining Wounds
☐ Bleeding Problems	☐ Skin Rash	

Please rate your pain:



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