Eaton Orthopaedics LLC
900 Carillon Parkway, Suite #311 • St. Petersburg, FL 33716
Phone: (727) 573-KOCO (5626) • Fax: (727) 573-5627
www.EatonOrtho.com

# PATIENT MEDICAL HISTORY

**Please answer all questions – Print all information. If uncertain, use a questions mark (?).**

NAME - LAST, FIRST, MIDDLE _____ BIRTHDATE _____ AGE _____ BIRTH PLACE _____ TODAY'S DATE _____

OCCUPATION _____ EMPLOYED BY _____ MARITAL STATUS **S M D W** _____ HEIGHT _____ WEIGHT

REASON YOU ARE BEING SEEN HERE? _____ IS THIS THE RESULT OF AN INJURY? _____ DATE OF INJURY _____

DID THIS INJURY HAPPEN AT WORK? _____ IS THIS INJURY RELATED TO CAR ACCIDENT? _____ DATE OF ACCIDENT _____

HAVE YOU HAD PAIN IN THE AFFECTED AREA PRIOR TO THE ACCIDENT/INJURY? _____ WHO REFERRED YOU TO OUR PRACTICE**?** _____

**PAST HISTORY:** GIVE AGE AT ONSET OF ANY OF FOLLOWING ILLNESSES YOU HAVE HAD.

| | | | | |
|---|---|---|---|---|
| Heart Disease | High Blood Pressure | Neuropathy | Asthma | Ulcers |
| Stroke | High Cholesterol | Fibromyalgia | Pneumonia | Kidney Stones |
| Atrial Fibrillation | Anemia | Anxiety | Tuberculosis | Kidney Disease |
| Seizure | Gout | Multiple Sclerosis | Polio | Liver Disease |
| Aneurysm | Sexually Transmitted Disease | Eye Disorder | Rheumatic Fever | Thyroid Disease |
| Cancer What Organ? | Diabetes Type? | Mental Illness | COPD | Arthritis? Rheumatoid? |

Have you tested Positive for HIV?_____ Have you tested Positive for Hepatitis?_____ If so what kind? _____

Do you have a history of Deep Vein Thrombosis or Pulmonary Embolism (blood clots)? _____

**FEMALES:** Are you pregnant? _____

Last menstrual period:_____ Cycle Length: _____ Age menses started:_____ Stopped:_____

**INJURIES:** LIST ALL SERIOUS INJURIES. INCLUDE BROKEN BONES, HEAD OR BACK INJURIES, AND DISLOCATIONS. GIVE YEAR OCCURRED

1._____ 2._____ 3._____

4._____ 5._____ 6._____

**SURGERY:** LIST ANY OPERATIONS.

1._____ 2._____ 3._____

4._____ 5._____ 6._____

**DO YOU USE TOBACCO NOW?**_____ **IN THE PAST?**_____ **TYPE**_____ **AMOUNT? DAILY**_____ **HOW LONG?**_____

**DO YOU USE ALCOHOLIC BEVERAGES?**_____ **IN THE PAST?**_____ **TYPE**_____ **AMOUNT? DAILY**_____ **HOWLONG?**_____

**HAND DOMINANCE: (Circle One) L R**

**MEDICATIONS:** LIST ALL MEDICATIONS THAT YOU TAKE REGULARLY OR FREQUENTLY. INCLUDE PRESCRIBED DRUGS, VITAMINS, ANTACIDS, BIRTH CONTROLL PILLS, ETC. ALSO INCLUDE FREQUENCY OF USE AND REASONS FOR USE.

| MEDICATION | DOSAGE | REASON YOU'RE TAKING |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PLEASE CONTINUE ON BACK IF NECESSARY**

**ALLERGIES:** LIST ALL KNOWN ALLERGIES TO MEDICATION, TYPE OF REACTION AND/OR STOMACH TROUBLE DUE TO MEDICATIONS.

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

**PLEASE CONTINUE ON BACK IF NECESSARY.**

**HOSPITALIZATIONS:** DO NOT LIST ANY NORMAL PREGNANCIES

| **MONTH & YEAR** | **REASON FOR HOSPITALIZATION** |
|---|---|
| 1._____ | _____ |
| 2._____ | _____ |
| 3._____ | _____ |
| 4._____ | _____ |
| 5._____ | _____ |

**IMMUNIZATIONS/DATE:**

TETANUS_____ MEASLES_____ HEPATITIS B_____ PNEUMONIA _____ TB SKIN TEST _____

| **LIST DATES OF MEDICAL TEST** | **RESULTS** |
|---|---|
| 1._____ | _____ |
| 2._____ | _____ |
| 3._____ | _____ |
| 4._____ | _____ |
| 5._____ | _____ |

**FAMILY HISTORY:**

| **FAMILY HISTORY** RELATION | AGE | STATE OF HEALTH | IF DECEASED, CAUSE OF DEATH | AGE AT DEATH |
|---|---|---|---|---|
| FATHER | | | | |
| MOTHER | | | | |
| BROTHERS AND SISTERS | | | | |
| | | | | |
| | | | | |
| SPOUSE | | | | |
| CHILDREN | | | | |
| | | | | |
| | | | | |

**CHECK IF ANY BLOOD RELATIVE HAS EVER HAD:** AND LIST RELATION

| ILLNESS | ✓ | RELATION | ILLNESS | ✓ | RELATION | ILLNESS | ✓ | RELATION |
|---|---|---|---|---|---|---|---|---|
| DIABETES TYPE? | | | THYROID | | | ANEURYSM | | |
| HIGH BLOOD PRESSURE | | | TUBERCULOSIS | | | ASTHMA | | |
| HEARTTROUBLE | | | EPILEPSY | | | ANEMIA | | |
| STROKE | | | ARTHRITIS | | | GASTRIC ULCERS | | |
| CANCER WHAT ORGAN? | | | PARKINSON'S DISEASE | | | MALIGNANT HYPERTHERMIA | | |
| KIDNEY TROUBLE | | | MENTAL ILLNESS | | | HIV | | |
| DVT / PE / BLOOD CLOT | | | BLOOD DISEASE | | | MULTIPLE SCLEROSIS | | |

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ Date _____

Eaton Orthopaedics LLC
900 Carillon Parkway, Suite #311 • St. Petersburg, FL 33716
Phone: (727) 573-KOCO (5626) • Fax: (727) 573-5627
www.EatonOrtho.com

# PRESCRIPTION DRUG POLICY

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from one of our physicians, you are also accepting responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe medications in appropriate dosages and amounts, with clear instructions. We will also inform you of the reason we are prescribing the drug, the expected benefits from its use and the major precautions and side effects. We will answer any questions you may have about the prescription drug you are being given.

Prescription drugs have potential for abuse and are regulated closely by state and federal agencies. Certain more closely controlled drugs (narcotic pain medications and tranquilizers) require even more responsibility on your part. We will accept **NO** excuses for their loss or theft and will not order replacements. We will not prescribe them if you are using them other than exactly as prescribed or receiving them from another source. We expect you to notify our office if you change drug stores or are getting medication from another source, so we may discontinue your prescription.

Many prescriptions drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue a medication, we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the correct course of action.

Our office also requires a 24-48 hour call-in policy for the refill of your prescriptions. When your medications are getting low and you feel you need a refill, please call our office with the name of your pharmacy and pharmacy phone number 24 to 48 hours prior so that we will have ample time to ask your treating physician and call your medication in to your pharmacy.

Failure to follow these policies will force our office to terminate our professional relationship with you and may require us to file a report with the Department of Professional Regulation (DPR) or the local police.

If you are in agreement with all of the information as provided above, please sign below that you agree to abide by these policies.

SIGNED:

_____
Patient/Guardian Signature & Date

Pharmacy Name:_____

Street Address:_____ City_____ State_____ Zip_____

Phone No.:_____

Eaton Orthopaedics LLC
900 Carillon Parkway, Suite #311 • St. Petersburg, FL 33716
**Phone: (727) 573-KOCO** (5626) • Fax: (727) 573-5627
www.EatonOrtho.com

# PATIENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be disclosed. Please review it carefully.

Eaton Orthopaedics, LLC will use your medical information for the following:

1. TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.

2. PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record(s) to pay the claim.

3. HEALTH CARE OPERATIONS: Any others involved in your healthcare.

The entire PRIVATE POLICY NOTICE of Eaton Orthopaedics, LLC, is posted in the waiting room for your perusal.

**QUESTION #1, 2, AND #3 MUST BE COMPLETED**

**In conjunction with these practices you will need to provide us with the following information:**

1. **Name of person(s) we may speak to regarding your health**
   (i.e. spouse, child, etc. Including phone number)

   _____

   _____

   _____

2. **Emergency Contact: (relative not living with you)**

   **Name:** _____

   **Address:** _____

   **Phone Number: (_____)** _____

3. **May we leave a message regarding your health or upcoming appointments on your answering machine?**

   **(Home)** **Yes:**_____ **No:**_____

   **(Work)** **Yes:**_____ **No:**_____

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name or Legal Guardian Patient's Date of Birth

**Koco Eaton, M.D. – *Sports Medicine, Orthopaedic Surgery***
**Douglas Carlan, M.D. – *Hand and Upper Extremity, Orthopaedic Surgery***
900 Carillon Parkway, Suite 311
St. Petersburg, FL 33716
Phone (727) 573-KOCO
Fax (727) 573-5627

# PATIENT INFORMATION RECORD

Patient Name_____ Email Address _____
First Middle Last

Street Address_____ Apt #_____ City_____ State_____ Zip_____

Out of State Address_____ Apt #_____ City_____ State_____ Zip_____

Date of Birth_____/_____/_____ Age_____ Gender ☐ M ☐ F Marital Status ☐ S ☐ M ☐ W ☐ D ☐ Sep

Social Security Number_____-_____-_____ Cell Phone _____ Home Phone_____

This information is **required** by the State of Florida and will be reported to the Agency for Health Care Administration. **http://ahca.myflorida.com**

Please complete the following:
☐ African American ☐ Asian ☐ Alaskan Native ☐ Hispanic ☐ Multiracial ☐Native American ☐ Other
☐ Pacific Islander ☐ Patient Declined ☐ Unknown by Patient ☐ White

Language:
☐ Cantonese ☐ English ☐ French ☐ German ☐ Indie ☐ Italian ☐ Japanese ☐ Mandarin
☐ Portuguese ☐ Russian ☐ Spanish ☐ Vietnamese ☐ Other

Occupation_____ Employer_____ Phone_____

Street Address_____ Suite_____ City_____ State_____ Zip_____

Patients Primary Doctor_____ Phone _____

Street Address_____ Suite_____ City_____ State_____ Zip_____

Referred by _____ Phone _____

Spouse (or Parent, if minor) _____
First Middle Last

Date of birth _____/_____/_____ Social Security Number _____-_____-_____ Phone _____

Street Address_____ Apt # _____ City_____ State_____ Zip_____

Occupation_____ Employer_____ Phone_____

Street Address_____ Suite_____ City_____ State_____ Zip_____

Emergency Contact _____ Relationship_____ Phone _____

Street Address_____ Apt #_____ City_____ State_____ Zip_____

**Primary Insurance Company** _____ Phone _____

Street Address_____ Suite_____ City_____ State_____ Zip_____

ID #_____ Policy # _____ Group #_____

Policy Holder's Name **(Required)**_____ Date of birth **(Required)**_____/_____/_____

Policy Holder's Address (if other than patient's): Phone _____ Relationship to Patient _____

Street Address_____ Apt #_____ City_____ State_____ Zip_____

Policy Holder's Employer (if other than patient's): _____ Phone _____

Street Address_____ Suite_____ City_____ State_____ Zip_____

**Other Insurance Company _** _____ Phone _____

Street Address_____ Suite_____ City_____ State_____ Zip_____

ID #_____ Policy # _____ Group #_____

Policy Holder's Name **(Required)**_____ Date of birth **(Required)**_____/_____/_____

Policy Holder's Address (if other than patient's): Phone _____ Relationship to Patient _____

Street Address_____ Apt #_____ City_____ State_____ Zip_____

Policy Holder's Employer (if other than patient's): _____ Phone _____

Street Address_____ Suite_____ City_____ State_____ Zip_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS I authorize payments of medical benefits to the provider of services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account SHOULD BE REFERRED TO A COLLECTION AGENCY, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

_____ _____ _____

Responsible Party Signature Relationship Date

Eaton Orthopaedics LLC
900 Carillon Parkway, Suite #311 • St. Petersburg, FL 33716
**Phone: (727) 573-KOCO** (5626) • Fax: (727) 573-5627
www.EatonOrtho.com

# *Patient Financial Policy – Insured*

Thank you for choosing Eaton Orthopaedics, LLC. Due to patient questions regarding their payment vs. insurance responsibility for services rendered, we have developed this financial policy. We encourage you to ask us any questions you may have about our policy.

***Insurance:*** We participate in most insurance plans, including Medicare. If you are not insured by a plan that we currently accept, or you do not have a valid insurance card, you are welcome to take advantage of our self pay rates.

***Co-Payments and Deductibles:*** *All co-payments and deductibles must be paid in full at the time of service.* This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from our patients can be considered fraud. Please help us uphold our agreement with your insurance company by paying your co-payment and/or deductible at each visit.

We always collect the ***anticipated*** office visit portion of your visit at check-in. This estimated fee amount **only** covers your time with the physician and/or any radiology needed. There are instances where additional, or less, time is required than anticipated and the actual fee will be adjusted when the claim is paid by your insurance company and a refund will be issued.

***Non-Covered Services:*** Please be aware that some, and perhaps all, of the services you receive may not be covered or considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

***Proof of Insurance:*** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your valid driver's license and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner you may be responsible for the balance of your claim.

***Claims Submission:*** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company since we are not party to that contract.

***Coverage Changes:*** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you do not provide us with the correct insurance information in a timely manner, you will be responsible for the entire balance.

***Nonpayment:*** If your account is over 120 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise arranged. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

***Outstanding Balances:*** It is your responsibility to keep your account with us current. This includes all outstanding balances due resulting from co-pays, deductibles, non-covered services, billing adjustments, etc. that are reflected in your Explanation of Benefits received from your insurance company and billing statements received from us. You must pay these outstanding balances in full prior to seeing the physician for your next appointment. **Non-receipt of a statement(s) from us does not excuse your obligation to pay your outstanding balance.**

_____ _____
Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____
Print Patient's Name or Legal Guardian | Date

# KOOS KNEE SURVEY

Today's date: _____/_____/_____ Date of birth: _____/_____/_____

Name: _____

**INSTRUCTIONS:** This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to perform your usual activities.
Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

## Symptoms

These questions should be answered thinking of your knee symptoms during the **last week**.

S1. Do you have swelling in your knee?

| Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?

| Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

S3. Does your knee catch or hang up when moving?

| Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

S4. Can you straighten your knee fully?

| Always | Often | Sometimes | Rarely | Never |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

S5. Can you bend your knee fully?

| Always | Often | Sometimes | Rarely | Never |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

## Stiffness

The following questions concern the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

S6. How severe is your knee joint stiffness after first wakening in the morning?

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

S7. How severe is your knee stiffness after sitting, lying or resting **later in the day**?

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

## Pain

P1. How often do you experience knee pain?

| Never | Monthly | Weekly | Daily | Always |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

What amount of knee pain have you experienced the **last week** during the following activities?

P2. Twisting/pivoting on your knee

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

P3. Straightening knee fully

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

P4. Bending knee fully

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

P5. Walking on flat surface

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

P6. Going up or down stairs

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

P7. At night while in bed

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

P8. Sitting or lying

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

P9. Standing upright

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

## Function, daily living

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A1. Descending stairs

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A2. Ascending stairs

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A3. Rising from sitting

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A4. Standing

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A5. Bending to floor/pick up an object

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A6. Walking on flat surface

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A7. Getting in/out of car

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A8. Going shopping

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A9. Putting on socks/stockings

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A10. Rising from bed

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A11. Taking off socks/stockings

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A12. Lying in bed (turning over, maintaining knee position)

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A13. Getting in/out of bath

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A14. Sitting

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A15. Getting on/off toilet

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

A17. Light domestic duties (cooking, dusting, etc)

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Function, sports and recreational activities**

The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your knee.

SP1. Squatting

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

SP2. Running

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

SP3. Jumping

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

SP4. Twisting/pivoting on your injured knee

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

SP5. Kneeling

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Quality of Life**

Q1. How often are you aware of your knee problem?

| Never | Monthly | Weekly | Daily | Constantly |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Q2. Have you modified your life style to avoid potentially damaging activities to your knee?

| Not at all | Mildly | Moderately | Severely | Totally |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Q3. How much are you troubled with lack of confidence in your knee?

| Not at all | Mildly | Moderately | Severely | Extremely |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Q4. In general, how much difficulty do you have with your knee?

| None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

***Thank you very much for completing all the questions in this questionnaire.***

eaton orthopaedics LLC

## Knee Pain Questionnaire

Name: _____ Age:_____ Date: _____

Which knee has pain? □Right □Left □Both

When did your present pain start (approximately what date)? _____

Was there a related injury/accident? □Yes □No Please explain: _____
_____

Please describe how your pain started: □No apparent cause
_____
_____
_____

Have you had similar pain in the past? □Yes □No If yes, when? _____

Where is the pain located? □Inside □Outside □Front □Back

Please indicate how severe your pain is now (0=no pain to 10=worst pain) _____

Which of the following activities produces pain?

□stairs □squatting □kneeling □pivoting □sitting □getting up □walking

How far can you walk before needing to rest?_____

Other _____

Which of the following symptoms do you have?

□locking □clicking □swelling □giving way □none

Which of the following treatments have you used?

□ice/heat NSAIDS (Motrin, Aleve, Celebrex) □Tylenol □physical therapy

□Glucosamine/chondroitin sulfate □Cortisone Injection

How much relief was provided? _____ How long did it last?_____

Do you use any of the following assistive devices?

□brace □crutches □cane □walker

Signature _____ Date _____