TEXAS KNEE INSTITUTE

GAE HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):			☐ Male ☐ Female	**DOB:**	
Marital status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
How did you hear about us?		☐ Doctor referral		☐ Friend / Family	
☐ Internet search		☐ Insurance plan		☐ Other	
Referring doctor:			**Primary Care Physician:**		
Orthopedist:			**Other doctor:**		
Pharmacy:			**Pharmacy Phone Number:**		

HISTORY OF PRESENT ILLNESS: (Please check all that apply)		
☐ Left knee pain	☐ Right knee pain	☐ Pain in both knees
☐ Aching pain	☐ Burning pain	☐ Throbbing pain
☐ Sharp pain	☐ Dull pain	☐ Tender to touch
☐ Swelling	☐ Catching / locking up	☐ Popping / clicking
☐ Buckling / giving way	☐ Instability	☐ Other:

FACTORS THAT MAKE YOUR SYMPTOMS WORSE: (check all that apply)		
☐ Sitting	☐ Standing	☐ Walking
☐ Lifting	☐ Twisting	☐ Bending
☐ Squatting	☐ Weight bearing	☐ Exercise
☐ Going from sit to stand	☐ Stairs	☐ Cold weather
☐ Other:		

FACTORS THAT MAKE YOUR SYMPTOMS BETTER: (check all that apply)		
☐ Nothing helps	☐ Sitting	☐ Standing
☐ Lying down	☐ Position change	☐ Heat
☐ Ice	☐ Rest	☐ Elevation
☐ Exercise	☐ Pain medication	☐ Other:

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PRIOR KNEE TREATMENTS: (check all that apply)		
☐ None	☐ Medications:________________________	
☐ Steroid injections	☐ Injections (Other):________________________	
☐ Physical therapy	☐ Surgery	☐ Arthroscopy (scope)
☐ Other		

PRIOR IMAGING		
☐ None	☐ X-Ray	☐ MRI
☐ CT (CAT Scan)	☐ Other	

OTHER MEDICAL PROBLEMS		
☐ Heart disease / CAD	☐ Peripheral arterial disease	☐ High blood pressure
☐ Stroke / TIA	☐ High cholesterol	☐ Diabetes
☐ COPD	☐ Hole in heart / Patent foramen ovale	☐ Migraines
☐ Blood clot / DVT	☐ Pulmonary embolus / PE	☐ Blood clotting disorder
☐ Kidney disease	☐ Hepatitis	☐ HIV / AIDS
☐ Fibromyalgia	☐ Rhematoid arthritis	☐ Other

SURGERIES	
Year	Operation

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MEDICATIONS:	
MEDICATION ALLERGIES:	☐ **No known drug allergies**

SOCIAL HISTORY		
Occupation:		
Does your job require prolonged standing?	☐ YES	☐ NO
Does your job require prolonged sitting?	☐ YES	☐ NO
Do your leg symptoms interfere with your work requirements?	☐ YES	☐ NO
Do you currently of have you ever smoked?	☐ YES	☐ NO
If you have smoked regularly, how many years have you smoked?		
If you have ever smoked, how many pack per day?		
How many alcoholic beverages do you consume per week?		

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CURRENT SYMPTOMS

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain

EYES
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Pain

EARS, NOSE, THROAT
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Nose Bleeds
- ☐ Sore Throat

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitaions
- ☐ Prior DVT (Blood Clot)
- ☐ Heart Defect

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea and Vomiting

GENITOURINARY
- ☐ Increased Urination
- ☐ Urinating at Night
- ☐ Bloody Urine
- ☐ Pelvic Pain
- ☐ Heavy Periods

MUSCULOSKELETAL
- ☐ Leg Pain
- ☐ Leg Swelling
- ☐ Back Pain

SKIN
- ☐ Wounds on Feet
- ☐ Skin Changes
- ☐ Skin Rashes or Itching

HEMATOLOGIC
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Blood Clots

NEUROLOGIC
- ☐ Restless Legs
- ☐ Numbness or Tingling
- ☐ Headaches (Migraines)
- ☐ Dizziness / Lightheaded
- ☐ Difficulty Walking

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Thoughts of Suicide

ENDOCRINE
- ☐ Frequent Thirst
- ☐ Frequent Urination
- ☐ Brittle Hair
- ☐ Crave Ice
- ☐ Hair Loss

OTHER
- ☐
- ☐
- ☐
- ☐
- ☐