# DR. XINNING LI - PATIENT HISTORY FORM

Today's Date: _____

Name: _____ BMC/BU MR #: _____

Date of Birth: _____ Age: _____ Who referred you to our office? _____

Primary Care Physician: _____

## KNEE HISTORY

Problem Knee: ❑ Right ❑ Left Prior Treatment: ❑ Yes ❑ No

Current Complaint: _____

_____

_____

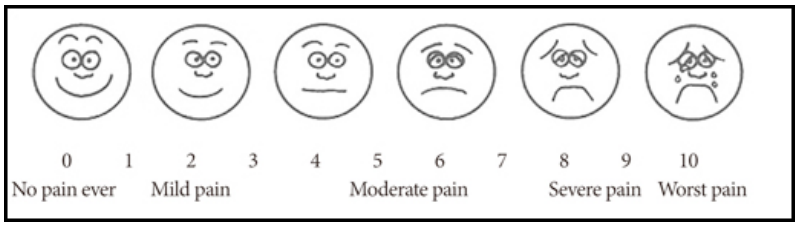
Do You Have Knee Swelling? ❑ Yes ❑ No Do You Have Clicking in Your Knee? ❑ Yes ❑ No

Do You Have Knee Stiffiness? ❑ Yes ❑ No Do You Have Knee Weakness? ❑ Yes ❑ No

Do You Have Night Pain? ❑ Yes ❑ No Does It Wake You Up at Night? ❑ Yes ❑ No

Knee Pain (0-10): Rest _____ Worst _____ Activities _____ Night _____

Please Circle Your Knee Pain Level:




Subjective Knee Value (%): Right _____ Left _____

(How do you rate your knee today between 0 to 100%? A non-functioning knee is 0% and a normal knee is 100%)

How Far Can You Walk? _____

Do You Have Back Pain? ❑ Yes ❑ No Do You Have Pain Down Your Legs? ❑ Yes ❑ No

Did You Injure Your Knee? ❑ Yes ❑ No

Date of Injury: _____ Is This Work Related? ❑ Yes ❑ No

Type of Injury: _____

_____

Previous Treatment: _____

_____

_____

Previous Knee Surgery: _____

Previous Orthopaedics Physician: _____

## WORK STATUS

Occupation: _____ Is this a work related injury (circle)? Yes / No

Current work status (circle): Full / Modified / Out of Work Last day worked: _____

Is there currently any litigation pending (circle)? Yes / No

## MEDICAL HISTORY

Height: _____ Weight: _____

List All Medical Conditions:

_____

_____

_____

_____

List All Previous Surgeries:

_____

_____

_____

_____

List All Medications & Dosages:

_____

_____

_____

_____

_____

List All Medication Allergies & Reactions:

_____

_____

_____

_____

Any problems with anesthesia? Yes / No

## FAMILY HISTORY

Do any illnesses run in your family? _____

Mother's Age: _____ Alive / Deceased Medical problems: _____

Father's Age: _____ Alive / Deceased Medical problems: _____

## SOCIAL HISTORY

Smoking (circle): Current (___ packs per day for ___ years) / Quit (year _____) / Never

Alcohol (circle): Current (daily / weekly / less often) / Quit (year ____) / Never

Recreational Drugs: _____

Have you ever been exposed to Hepatitis or AIDS (circle)? Yes / No

## REVIEW OF SYSTEMS

Check all that apply to your health

Constitutional
- ❑ Fever, Chills, Sweats
- ❑ Weight loss
- ❑ Change in appetite
- ❑ Excessive fatigue

Respiratory
- ❑ Date/Location of last chest xray
- ❑ Sleep apnea
- ❑ Asthma, wheezing
- ❑ COPD
- ❑ Chronic cough
- ❑ Blood in sputum
- ❑ Lung cancer
- ❑ Pneumonia or bronchitis

Musculoskeletal
- ❑ Swelling in multiple joints
- ❑ Excessive flexibility of joints
- ❑ Broken bones, which? _____
- ❑ Dislocated joints, which? _____
- ❑ Fibromyalgia
- ❑ Reflex Sympathetic Dystrophy

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Claustrophobia

Hematologic/Immunology
- ❑ Easy bleeding/bruising
- ❑ Blood transfusions
- ❑ Decreased resistance to infections

Eyes, Ears, Nose, & Throat
- ❑ Recent changes in vision
- ❑ Glaucoma
- ❑ Metal fragments in eyes
- ❑ Nosebleeds
- ❑ Hearing loss
- ❑ Poor balance

Gastrointestinal
- ❑ Ulcers or gastritis
- ❑ Nausea or vomiting
- ❑ Jaundice or liver problem
- ❑ Gallbladder problem
- ❑ GERD/heartburn
- ❑ Blood in stool
- ❑ Colon cancer

Skin
- ❑ Chronic rashes
- ❑ Eczema or Psoriasis
- ❑ Skin cancer
- ❑ Breast lump/nipple discharge

Endocrine
- ❑ Diabetes
- ❑ Thyroid problems
- ❑ Hormone Replacement Therapy
- ❑ Taken Prednisone
- ❑ Anemia

Cardiovascular
- ❑ Date/Location of last EKG
- ❑ Chest pain or Angina
- ❑ High blood pressure
- ❑ Heart murmur
- ❑ Irregular pulse
- ❑ Elevated Cholesterol
- ❑ Calf pain when walking

Genitourinary
- ❑ Bladder infections
- ❑ Blood in urine
- ❑ Difficulty with urination
- ❑ Kidney stones
- ❑ Prostate problems
- ❑ Abnormal pap smear

Neurological
- ❑ Seizures
- ❑ Leg pain/sciatica
- ❑ Weakness of a limb
- ❑ Numbness of a limb
- ❑ Loss of sensation of a limb
- ❑ Bowel/bladder control loss
- ❑ Stroke
- ❑ Loss of memory

The above information is accurate to the best of my knowledge

Patient Signature _____ Date _____

I have reviewed this information with the patient

Clinician Signature _____ Date _____