

NEW KNEE TEMPLATE

DATE: _____ ACCOUNT #: _____ TYPE (CIRCLE): OP NP

PLEASE COMPLETE THE FOLLOWING INFORMATION:

YOUR NAME: _____ YOUR AGE: _____ GENDER: M F

YOUR OCCUPATION: _____ Is this injury work related? Y N

YOUR FAMILY DOCTOR NAME & ADDRESS: _____

YOUR REFERRING DOCTOR NAME & ADDRESS: _____

THE CHIEF COMPLAINT: LEFT knee problem RIGHT knee problem BOTH knees – worse on RIGHT/LEFT (circle one)

WHICH BEGAN ON: ____/____/____ (approximate date)

CIRCUMSTANCES OF ONSET WERE: Gradual Sudden

WHAT TYPE OF INJURY? (check any that apply):

- No specific injury Noncontact injury
- Contact injury Pivot injury (Felt a pop - did not feel a pop)
- Other : _____

HAVE YOU HAD ANY PRIOR KNEE PROBLEMS? Y N **WHICH KNEE?** Right Left

NATURE OF PROBLEM: Sprain Arthritis Meniscus tear Date _____

Prior surgery Y N Procedure: _____

Arthroscopic Meniscus ACL Arthritis Right Left
(Date) ____/____/____

Arthroscopic Meniscus ACL Arthritis Right Left

ADDITIONAL KNEE HISTORY: _____

(Check any that apply)

LOCATION OF DISCOMFORT: in the front in the back on the inside on the outside all around in the calf in the thigh

CURRENT LEVEL OF DISCOMFORT:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

THE DISCOMFORT IS: GETTING BETTER GETTING WORSE UNCHANGED

THE QUALITY OF DISCOMFORT IS: CONSTANT INTERMITTENT SHARP DULL THROBBING

IS THERE RADIATION OF DISCOMFORT? No Yes- to-the- Hip Thigh Calf Foot? Quadriceps Hamstrings

DO YOU PARTICIPATE IN ANY SPORTS OR VIGOROUS ACTIVITIES? YES NO

Please indicate the degree of difficulty you have experienced in the **past week** due to your knee problem.
Please choose only one box and please answer every question

CHECK IF YOU HAVE:

| | | | None | Mild | Moderate | Severe | Extreme |
|-------------------------------------|-------------------------------------|--------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Locking | Rising from bed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Grinding | Putting on socks/stockings | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Rest pain | <input type="checkbox"/> Giving Way | Rising from sitting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Popping | <input type="checkbox"/> Catching | Bending to the floor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Night pain | <input type="checkbox"/> Buckling | Twisting/pivoting on your knee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | Kneeling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | Squatting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| |
|--|
| Physician use only: KOOS Score: |
|--|

TREATMENTS TRIED FOR THIS PROBLEM: NONE ER VISIT: WHERE? _____ – DATE: ____/____/____

Synvisc/Hyalgan/Supartz Inj. PT (how long?) _____ Crutches/cane
 Rest Applied Ice Cortisone Inj. (how many?) _____
 Over the counter Meds (Name) _____ Applied Heat Bracing (type) _____
 Prescription Meds (name) _____ Exercises Activity Modifications

WERE ANY OF THE ABOVE TREATMENTS HELPFUL/WHICH ONES? Y N - _____

(OFFICE USE ONLY)

TRUE CONSULTATION AND REQUESTED BY DR: _____

OUTSIDE MEDICAL RECORDS REVIEWED

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OBJECTIVE EXAMINATION: (TO BE COMPLETED BY THE PHYSICIAN)

BUILD - Ectomorph Endomorph Mesomorph

APPEARANCE: WDNW Alert Oriented x 3
 No acute distress In obvious pain Anxious Depressed
 Deformity Older than stated age Disoriented

GAIT: Normal Limp Crutches Cane Wheelchair Unable to weight bear Trendelenburg

POSTURE: Normal List to the RIGHT LEFT

SKIN: Normal RIGHT LEFT BILATERAL

Rash Scars Erythema Ecchymosis Abrasions (location) _____

LYMPH: Normal Lymphadenitis Lymphadenopathy RIGHT LEFT BILATERAL

CIRCULATION: PULSES- Normal - Decreased (PT DP) (check any that apply)-

Edema (1+ 2+) R L B Clubbing R L B

Varicosities R L B Cyanosis R L B

Trophic changes R L B Stasis dermatitis R L B

NEURO EXAM: Normal exam -

Motor Normal Weak - EHL Calf Hamstring Quad R L B

Sensory: Normal Decreased - Anterior thigh Medial leg/foot Lateral leg/foot R L B

DTR's: Normal Decreased - Knee jerk Ankle jerk R L

RIGHT

SQUAT Normal Unable

ALIGNMENT Normal Varus Valgus Recurvatum _____

FEET Normal Pronation Supination

HIP ROM Normal Limited Painful

QUAD ATROPHY No Mild Moderate Severe

EFFUSION No Mild Moderate Severe

GRIND/CREPITUS None Present Severe

LEFT

Normal Unable

Normal Varus Valgus Recurvatum _____ degrees

Normal Pronation Supination

Normal Limited Painful

No Mild Moderate Severe

No Mild Moderate Severe

None Present Severe

KNEE ROM Normal

EXTENSION +20 10 0 -10 20 -30 -45 Painful Pain free

FLEXION 30 45 65 95 105 115 125 135 145 Painful Pain free

Normal

+20 10 0 -10 20 -30 -45 Painful Pain free

30 45 65 95 105 115 125 135 145 Painful Pain free

PATELLA Normal Normal except:

HYPERMOBILE No Yes

CREPITUS No Yes

PAIN W/ PALPATION No Yes

APPREHENSION No Yes

Q ANGLE Normal Increased

LATERAL RETINACULAR Normal Tight

SUBLUXABLE No Yes

Normal Normal except:

No Yes

No Yes

No Yes

No Yes

Normal Increased

Normal Tight

No Yes

SPRING SIGN Negative Painful Soft endpoint

MCMURRAY'S Negative Medial Lateral Unable

STEINMANN Negative Medial Lateral

Negative Painful Soft endpoint

Negative Medial Lateral Unable

Negative Medial Lateral

TENDERNESS: Negative -

Medial joint line Anterior Mid

Lateral joint line Anterior Mid

Posterior R L B

Posterior R L B

Adductor tubercle R L B

Along saphenous nerve R L B

Anterior tibia R L B

Anterolateral tibia R L B

Anteromedial tibia R L B

Fibular head R L B

IT band R L B

Lateral hamstrings R L B

LCL R L B

LFC R L B

MCL R L B

Medial hamstring R L B

Medial retinaculum R L B

MFC R L B

Patella R L B

Patellar tendon R L B

Plica R L B

Posterior tibia R L B

Prepatellar bursa R L B

Quad R L B

Quad Tendon R L B

Tibial tubercle R L B

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RIGHT

STABILITY Normal exam

Varus at 0 degrees Normal 1 2 3 4

Valgus at 0 degrees Normal 1 2 3 4

Varus at 30 degrees Normal 1 2 3 4

Valgus at 30 degrees Normal 1 2 3 4

Lachman Negative Positive

 Endpoint with without

Anterior drawer Normal 1 2 3 4

Posterior drawer Normal 1 2 3 4

Reverse pivot Negative Positive

Pivot Negative Mild Mod. Mark Unable

LEFT

Normal exam

Normal 1 2 3 4

Normal 1 2 3 4

Normal 1 2 3 4

Normal 1 2 3 4

Negative Positive

with without

Normal 1 2 3 4

Normal 1 2 3 4

Negative Positive

Negative Mild Mod. Mark Unable

X-RAYS **RIGHT** # OF VIEWS: _____

Normal x-rays:
AP, lateral, tunnel, and merchant views of the affected knee(s) were obtained in the office today, and reveal no periosteal reaction, no medullary lesions, no osteopenia, well aligned joint spaces and no chondrolysis.

Normal x-rays except, report dictated (STATE VIEWS OR # OF VIEWS)

Abnormal x-rays, report dictated

Outside x-rays and/or MRI's were reviewed

LEFT # OF VIEWS: _____

Normal x-rays:
AP, lateral, tunnel, and merchant views of the affected knee(s) were obtained in the office today, and reveal no periosteal reaction, no medullary lesions, no osteopenia, well aligned joint spaces and no chondrolysis.

Normal x-rays except, report dictated

Abnormal x-rays, report dictated

Outside x-rays and/or MRI's were reviewed

MRI: DATE: ____/____/____ RESULTS:

RIGHT Normal Chondromalacia patella

LEFT Effusion Chondral Damage

BILATERAL Medial meniscus tear Lateral meniscus tear

MCL ACL PCL LCL

Early DJD Moderate DJD Severe DJD Baker's Cyst

BONE SCAN: DATE: ____/____/____ RESULTS: Normal Increased uptake

RIGHT LEFT BILATERAL

LAB STUDIES:

| | NORMAL | ABNORMAL |
|------------|--------|----------|
| RA | _____ | _____ |
| Lyme titer | _____ | _____ |
| ANA | _____ | _____ |
| ESR | _____ | _____ |
| CBC | _____ | _____ |
| Uric acid | _____ | _____ |
| HLA - B27 | _____ | _____ |

ULTRA SOUND: DATE: ____/____/____ RESULTS: Negative Positive- Popliteal cyst DVT

DIAGNOSIS: LEFT KNEE RIGHT KNEE BILATERAL KNEES

RULE OUT:

| | | | | | | | | | |
|---|--------|---|---|---|---|--------|---|---|---|
| <input type="checkbox"/> ACL tear | 844.2 | R | L | B | <input type="checkbox"/> Traumatic osteoarthritis | 716.16 | R | L | B |
| <input type="checkbox"/> Baker's cyst | 727.51 | R | L | B | <input type="checkbox"/> Patellar subluxation | 836.3 | R | L | B |
| <input type="checkbox"/> Chondromalacia patella | 717.7 | R | L | B | <input type="checkbox"/> Patellar tendinitis | 726.64 | R | L | B |
| <input type="checkbox"/> Contusion | 924.11 | R | L | B | <input type="checkbox"/> Patellar tendon rupture | 727.66 | R | L | B |
| <input type="checkbox"/> Dislocation patella | 836.3 | R | L | B | <input type="checkbox"/> PCL sprain | 844.2 | R | L | B |
| <input type="checkbox"/> Dislocation patella Rec. | 718.36 | R | L | B | <input type="checkbox"/> Pes Bursitis | 726.61 | R | L | B |
| <input type="checkbox"/> Effusion | 719.06 | R | L | B | <input type="checkbox"/> Plica | 727.83 | R | L | B |
| <input type="checkbox"/> Fracture patella | 822.0 | R | L | B | <input type="checkbox"/> Prepatellar Bursitis | 726.65 | R | L | B |
| <input type="checkbox"/> Gout | 274.9 | R | L | B | <input type="checkbox"/> Pseudogout | 712.16 | R | L | B |
| <input type="checkbox"/> Hemarthrosis | 719.16 | R | L | B | <input type="checkbox"/> Quad tendinitis | 726.69 | R | L | B |
| <input type="checkbox"/> Hip arthritis | 715.15 | R | L | B | <input type="checkbox"/> Quad tendon rupture | 727.65 | R | L | B |
| <input type="checkbox"/> IT band tendinitis | 726.69 | R | L | B | <input type="checkbox"/> Sciatica | 724.3 | R | L | B |
| <input type="checkbox"/> Lateral meniscus tear | 836.1 | R | L | B | <input type="checkbox"/> Sprain | | R | L | B |
| <input type="checkbox"/> Loose body | 717.6 | R | L | B | <input type="checkbox"/> Strain | | R | L | B |
| <input type="checkbox"/> Med collateral lig tear | 844.1 | R | L | B | <input type="checkbox"/> Stess Fx _____ | | R | L | B |
| <input type="checkbox"/> Medial meniscus tear | 836.0 | R | L | B | <input type="checkbox"/> Synovitis | 719.26 | R | L | B |
| <input type="checkbox"/> OCD | 732.7 | R | L | B | <input type="checkbox"/> Other _____ | | | | |
| <input type="checkbox"/> Osgood-Schlatter | 732.4 | R | L | B | | | | | |
| <input type="checkbox"/> Osteoarthritis | 715.16 | R | L | B | | | | | |

OTHER DIAGNOSIS: Obesity Diabetes Stroke Lyme's disease Rheumatoid Arthritis Gout

THE ORTHOPAEDIC & SPORTS MEDICINE CENTER
PATIENT TREATMENT PLAN
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PATIENT'S NAME: _____ **Date:** _____

RECOMMENDATIONS:

- | | | |
|---|--|---|
| <input type="checkbox"/> Counseling <input type="checkbox"/> Information booklet <input type="checkbox"/> Question/Answer sheet <input type="checkbox"/> Exercise program <input type="checkbox"/> Handicap parking permit application <input type="checkbox"/> Top 10 for arthritis <input type="checkbox"/> Video teaching <input type="checkbox"/> Apply ice <input type="checkbox"/> Information on | <input type="checkbox"/> Synvisc <input type="checkbox"/> Hyalgan <input type="checkbox"/> Supartz <input type="checkbox"/> Orthovisc | Activity Modifications: <input type="checkbox"/> Avoid impact loading/running/jumping <input type="checkbox"/> Avoid squatting, twisting or pivoting <input type="checkbox"/> Off work/school/sports ___ days ___ weeks ___ months <input type="checkbox"/> Light duty (restricted to sitting, walking > 100 ft. and no carrying objects > 10 lbs.) <input type="checkbox"/> Avoid bending the knee beyond 30 degrees |
|---|--|---|

PROCEDURE NOTE:

- Aspiration cc: _____
 Clear Cloudy Bloody Fluid sent for lab tests
 Injection; Cortisone cc: _____
 Injection: Synvisc Hyalgan Supartz Orthovisc

MEDICATIONS PRESCRIBED: New Prescription Continue Medication-

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Tylenol 2 XS 4x/day | <input type="checkbox"/> Glucosamine 1500/day – Chondroitin 1200/day | <input type="checkbox"/> Multivitamin daily | <input type="checkbox"/> ibuprofen |
| <input type="checkbox"/> <u>Antiinflammatories-</u> <input type="checkbox"/> Motrin | <input type="checkbox"/> Celebrex | <input type="checkbox"/> Arthrotec | <input type="checkbox"/> Mobic |
| <input type="checkbox"/> <u>Pain med-</u> <input type="checkbox"/> Percocet | <input type="checkbox"/> Lortab | <input type="checkbox"/> Darvocet | <input type="checkbox"/> Ultracet ER |
| | | <input type="checkbox"/> Relafen | <input type="checkbox"/> Lodine <input type="checkbox"/> Naprosyn |
| | | <input type="checkbox"/> Other | <input type="checkbox"/> OTC NSAIDS |

THE PATIENT SHOULD OBTAIN/CONTINUE:

- | | | |
|--|-----|-----|
| <input type="checkbox"/> Arthritis seminar | ___ | ___ |
| (CALL 443-481-4000) | | |
| <input type="checkbox"/> Cane/crutches/walker | ___ | ___ |
| <input type="checkbox"/> Wedges | ___ | ___ |
| <input type="checkbox"/> Orthotics | ___ | ___ |
| <input type="checkbox"/> Weight loss program | ___ | ___ |
| <input type="checkbox"/> Water aerobic program | ___ | ___ |

BRACING: OBTAIN/CONT.:

- | | | |
|--|-----|-----|
| <input type="checkbox"/> Cho Pat | ___ | ___ |
| <input type="checkbox"/> Derotation | ___ | ___ |
| <input type="checkbox"/> hinged knee | ___ | ___ |
| <input type="checkbox"/> Pat. stabilizer | ___ | ___ |
| <input type="checkbox"/> sleeve | ___ | ___ |
| <input type="checkbox"/> unloader | ___ | ___ |
| <input type="checkbox"/> arch supports | ___ | ___ |
| <input type="checkbox"/> knee imbol. | ___ | ___ |
| <input type="checkbox"/> exten. board | ___ | ___ |
| <input type="checkbox"/> TED stocking | ___ | ___ |

TO OBTAIN BEFORE NEXT VISIT:

- Bone Scan
 MRI
 CT Scan
 Blood tests
 Synvisc (and insurance approval)
 Hyalgan (and insurance approval)
 Supartz (and insurance approval)
 Orthovisc (and insurance approval)

THE PATIENT WILL BE SENT FOR:

- Consultation with Dr. _____
 PT arthritis consult PT consult Pre-op visit Other _____

SURGERY:

- Not discussed/not indicated at this time
 Briefly discussed, pursue nonsurgical treatment for now
 Was discussed, may proceed pending- Diagnostic test results Response to treatment
 Surgical options below thoroughly discussed for consideration
- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Ligament reconstruction | <input type="checkbox"/> Patellar realignment |
| <input type="checkbox"/> Total knee | <input type="checkbox"/> Uni-knee | <input type="checkbox"/> Other- _____ |

RETURN FOR FOLLOW UP VISIT IN:

- ___ Days ___ Weeks ___ Months ___ as needed, if worsened or not improved _____ Pre-op
- After test results are obtained After MRI obtained Will call to schedule appt.
 Will return for Orthovisc inj Returned to care of PCP (consults)

X-Rays on follow up:

- No new x-rays on follow up
 X-rays in AP, lateral, tunnel and merchant views of the R L Bil knee on follow up.
 X-rays other: _____