

## Functional History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

<b>Chief Complaint:</b> ( Reason for Visit )  _____	<input type="checkbox"/> Hip  <input type="checkbox"/> Knee	<input type="checkbox"/> Right <input type="checkbox"/> Right > Left <input type="checkbox"/> Left <input type="checkbox"/> Left > Right <input type="checkbox"/> Both
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### Severity of Pain :

1. On a scale of 0 to 10 with 0 meaning "no pain" and 10 meaning "extreme pain", please describe how your affected joint usually feels. (circle one)

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

2. Which of the following categories would best describe your affected joint pain?

- None
- Mild – I have slight/occasional pain that has not caused me to alter how I am and how much I work / play.
- Moderate – I am active but I have had to modify or give up some of my activities because of pain.
- Severe – I have major pain and serious limitations

3. How much joint pain do you experience when you are at rest?

- None    Mild    Moderate    Severe

### Frequency of Pain:

1. If you have pain, how often?

- Never
- Only occasionally and intermittently.
- Only when I first get up from a sitting or standing position
- Only with walking more than 30 minutes
- Anytime I walk
- At all times

### Location of Pain : (check all that apply)

1. If you have pain in your **knee**, where do you feel it? (you may choose more than one answer)

- In the front of the knee
- In the inner side of the knee (medial)
- In the outer side of the knee (lateral)
- In the back of the knee
- Diffusely in the entire knee area
- Not applicable / no pain

2. If you have pain in your **hip**, where do you feel it? (you may choose more than one answer)

- In the groin
- In the front of the thigh
- On the side of the hip
- In the buttock
- Not applicable / no pain

3. Does your pain radiate / travel anywhere?

- To the lower back
- Across to the other hip / knee
- To the mid thigh / knee (same side)
- To the lower leg / foot
- Not applicable / no radiation

### Additional pain / other joint affliction:

1. Do you regularly have pain in any other joints?    Yes    No   (if "No", please skip next 2 questions)

2. How severe is the additional pain?   No pain   Extreme Pain  
 0 1 2 3 4 5 6 7 8 9 10

3. Where is the additional pain?

- |   |   |  |              |
|---|---|--|--------------|
| <input type="checkbox"/> Not applicable / No pain | Same side: <input type="checkbox"/> Hip | Other side: <input type="checkbox"/> Hip | Other: _____ |
| <input type="checkbox"/> Lower Back               | <input type="checkbox"/> Knee           | <input type="checkbox"/> Knee            | _____        |
| <input type="checkbox"/> Neck                     | <input type="checkbox"/> Ankle          | <input type="checkbox"/> Ankle           | _____        |

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

## Functional History (continued)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Activity Level:**

1. Which is your current activity level?
  - Bedridden or confined to a wheelchair
  - Sedentary with minimal capacity for walking or other basic activity
  - Capable of light labor, such as house cleaning, yard work, assembly line work, or light sports
  - Capable of moderate manual labor, such as lifting heavy weights, or participate in moderately strenuous sports (walking, bicycling)
  - Capable of heavy manual labor. Frequently lift heavy weights, and participate in vigorous sports (tennis, running)
2. What is your current work capacity? (percent of normal)
  - 100%    75%    50%    25%    0 %

**Specific Physical Activities:**

1. How long can you walk without support ( no cane, crutch or walker)?
  - Unlimited – more than 60 minutes
  - 31 – 60 minutes
  - 11 – 30 minutes
  - 2 - 10 minutes
  - less than 2 minutes
  - Unable to walk without support
2. How long can you walk with support (cane, crutch or walker)?
  - Unlimited – more than 60 minutes
  - 31 – 60 minutes
  - 11 – 30 minutes
  - 2 - 10 minutes
  - less than 2 minutes
  - Unable to walk without support
3. How far can you walk without stopping because of joint pain?
  - Unlimited distance
  - More than 10 blocks
  - Between 5 - 10 blocks
  - Less than 5 blocks
  - Indoors – minimal distance
  - Confined to Wheelchair / bed

**Specific Physical Activities (continued):**

4. How long can you sit comfortably in a chair?
  - Over an hour
  - 30 – 60 minutes
  - Less than 30 minutes
  - Unable to sit comfortably for any time period
5. How do you stand up from a sitting position?
  - Without assistance from my arms
  - With one arm push-off assistance
  - With both arms push-off assistance
  - Unable to stand without another person's assistance
6. How do you put on your socks and shoes?
  - Without difficulty
  - With slight difficulty
  - With moderate difficulty
  - Unable without assistance
7. How do you go up and down the stairs?
  - Normally (walking through with one foot on each step)
  - Normally but with assistance of the rail
  - With difficulty: one step at a time and holding onto the rail
  - With great difficulty: crawling or backwards
  - Unable to perform stair climbing
8. How do you get in and out of a car?
  - Without difficulty
  - With slight difficulty
  - With moderate difficulty
  - Unable without assistance
9. Can you manage public transportation?
  - Without difficulty    With difficulty    Unable
10. Does this specific joint pain disturb your sleep?
  - Yes    No
11. Does this specific joint pain interfere with your sexual life?
  - Yes    No

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Patrick A. Meere, MD

## Functional History (continued)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Assist Devices :**

1. What level of support do you require when walking?

- No support necessary
- Single cane for long walks
- Single cane most of the time
- One crutch
- Two crutches
- A walker
- Unable to walk

**Medical Treatment :** (check all that apply)

1. What medication have you used for this condition?  
(you may choose more than one answer)  
( please indicate if still effective at present Y / N

- Anti-inflammatory medication  
(eg aspirin, Motrin, Naprosyn)
- Cox II inhibitor medication  
(Celebrex, Vioxx, Bextra)
- Chronic steroid treatment (Prednisone)
- Codeine level pain killers
- Narcotic level pain killers
- Other: \_\_\_\_\_
- Not applicable / none

**Physiotherapy:**

1. Have you received any physiotherapy for this condition?

- Yes  No

2. Was it effective at controlling the symptoms?

- Very effective
- Moderately effective
- Mildly effective
- Not effective

3. For how long did the physiotherapy help you?

- greater than 3 months
- Between 6 weeks and three months
- Less than six weeks
- Not helpful at all

2. What other treatments have you received for this condition?  
(you may choose more than one answer)

- Joint injection (steroids)
- Joint viscosupplementation (Synvisc, Hyalgan)
- Joint aspiration
- Arthroscopy
- Not applicable / none

**Aggravating Factors:** (please choose all that apply – you may select more than one answer)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Prolonged standing          | <input type="checkbox"/> Squatting             | <input type="checkbox"/> Stair climbing          |
| <input type="checkbox"/> Prolonged sitting           | <input type="checkbox"/> Lifting heavy objects | <input type="checkbox"/> Rising from a low chair |
| <input type="checkbox"/> Walking more than 5 minutes | <input type="checkbox"/> Pushing / pulling     | <input type="checkbox"/> Other: _____            |

**Alleviating Factors:** (please choose all that apply – you may select more than one answer)

	Useless									Very Helpful	
	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Medications	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Physiotherapy	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Restriction of excessive activities	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Weight loss	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Therapeutic injection	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Use of assist devices	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Use of a brace / orthotic	0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/> Other: _____	0	1	2	3	4	5	6	7	8	9	10

Reviewed by: \_\_\_\_\_

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