Intermountain Healthcare
Healing for life℠

TOSH Knee Program
The Orthopedic Specialty Hospital
5848 South Fashion Blvd
Murray Utah 84107

Patient Name: _____ **Date:** _____ **Age:** _____ **Gender:** M / F

Occupation: _____ Are you currently working: YES / NO

Injured doing: Insidious or Unsure / Sports / Work / Auto Date: _____/_____/_____

Side: Left / Right / Bilateral **Job Related Injury:** YES /NO **Duration of Symptoms:** _____wk/mo/yr

Are you currently taking medications for your knee pain? YES / NO List: _____

Activity Level

1. Prior to knee pain/injury: Sedentary / Recreational / Competitive / Collegiate
2. Sport/ Hobbies: _____

Treatment / Imaging

1. Have you had any of the following? Please check all that apply

___ X-rays ___ MRI ___ Physical Therapy
___ Injections (knee joint) ___ Anti-inflammatories ___ Activity Modification

2. If you have seen physical therapy, how long did you participate in a formal therapy program?
   a. _____ days _____ weeks _____ months b. Did it help? _____ Yes _____No

(For the Next 5 questions, please circle all that apply)

Symptoms: Pain Weakness Instability/Dislocation Stiffness Swelling
Buckling Locking Grinding Clicking Catching

Location: Medial (inside) Lateral (outside) Front Back

Describe your symptoms: Sharp Ache Constant Intermittent Burning

What causes pain/instability: Walking Stairs Running Squatting
Pivoting / Twisting Sitting With Knee Bent Lifting Objects
Other: _____

What decreases your pain? Nothing Rest Activity modification Meds
Other: _____

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? __ Not at all __ Somewhat difficult ___ Very Difficult __ Extremely difficult

Over the past two weeks, have you been bothered by any of the following problems?

1. Little interest in doing things?
   0=Not at all 1= Several days 2=More than ½ the days 3= Nearly everyday
2. Feeling down, depressed, or hopeless?
   0=Not at all 1= Several days 2=More than ½ the days 3= Nearly everyday

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MEDICAL HISTORY FORM

Email Address: _____

Primary Care Physician:_____

Who Referred you to us:_____

Height:_____ ft _____ in

Weight: _____lbs

Past Medical History O None

Do you Have any of the Following Conditions?
(check all that apply)

O Diabetes
O High Blood Pressure
O Heart Disease
O High Cholesterol
O Stroke
O Kidney Disease
O Thyroid Disease
O Hepatitis
O Lung Disease
O AIDS/HIV
O Chronic Obstructive Pulmonary Disease
O Obstructive Sleep Apnea
If yes, Do you use a CPAP? O Yes O No
O Blood Clots
Was it in the lung? O Yes O No
Is there a Family History of Blood Clots?
O Yes O No If yes, who?_____

Past Surgical History O None

_____
_____
_____
_____

Current Medications/Dosage O None (or attach sheet)

_____
_____
_____
_____

Drug/Other Allergies O No Known Allergies

_____
_____
_____

Social History

Do you use Tobacco? O Yes O No O Quit
Do you Drink Alcohol O Yes O No
If yes, how many drinks per week _____
How do you sleep at night?
O Fine/No issues O With Difficulty
O Only with Medications
Have you ever had an addiction problem?
O Yes O No If yes, what? _____

Review of Systems:

Please Check Circle if you (1) have or have had in the past AND/OR (2) if you are being treated for:

Constitutional

O Weight Gain
O Fatigue
O Trouble Sleeping
O Depression
O Cancer
O Overweight

Gastrointestinal

O Heart Burn
O Vomiting Blood
O Stomach Ulcers
O Blood Stools
O Liver Disease
O Constipation
O Stomach Pain

Respiratory

O Asthma
O Shortness of Breath
O Cough
O Pulmonary Embolus
O Cough up Blood

Cardiovascular

O Angina/Chest Pain
O Heart Attack
O Heart Murmur
O Anemia
O Blood Clot
O Easy Bleeding/Bruising

Joint Problems

O Rheumatoid Arthritis
O Gout
O Inflammatory Arthritis
O Lyme Disease

Neurological

O Numbness
O Seizures
O Headaches
O Anxiety

Endocrine

O Diabetes
O Thyroid Disease
O Adrenal Disease

Other

O Alcoholism
O Drug Addiction
O Kidney Disease

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2000 IKDC SUBJECTIVE KNEE EVALUATION FORM

Your Full Name_____

Today's Date: _____/_____/_____ (Day / Month / Year) Date of Injury: _____/_____/_____ (Day / Month / Year)

SYMPTOMS*:

*Grade symptoms at the highest activity level at which you think you could function without significant symptoms, even if you are not actually performing activities at this level.

1. What is the highest level of activity that you can perform without significant knee pain?

4❑ Very strenuous activities like jumping or pivoting as in basketball or soccer
3❑ Strenuous activities like heavy physical work, skiing or tennis
2❑ Moderate activities like moderate physical work, running or jogging
1❑ Light activities like walking, housework or yard work
0❑ Unable to perform any of the above activities due to knee pain

2. During the past 4 weeks, or since your injury, how often have you had pain?

	0	1	2	3	4	5	6	7	8	9	10	
Never	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	Constant

3. If you have pain, how severe is it?

	0	1	2	3	4	5	6	7	8	9	10	
No pain	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	Worst pain imaginable

4. During the past 4 weeks, or since your injury, how stiff or swollen was your knee?

4❑ Not at all
3❑ Mildly
2❑ Moderately
1❑ Very
0❑ Extremely

5. What is the highest level of activity you can perform without significant swelling in your knee?

4❑ Very strenuous activities like jumping or pivoting as in basketball or soccer
3❑ Strenuous activities like heavy physical work, skiing or tennis
2❑ Moderate activities like moderate physical work, running or jogging
1❑ Light activities like walking, housework, or yard work
0❑ Unable to perform any of the above activities due to knee swelling

6. During the past 4 weeks, or since your injury, did your knee lock or catch?

0❑ Yes 1❑ No

7. What is the highest level of activity you can perform without significant giving way in your knee?

4❑ Very strenuous activities like jumping or pivoting as in basketball or soccer
3❑ Strenuous activities like heavy physical work, skiing or tennis
2❑ Moderate activities like moderate physical work, running or jogging
1❑ Light activities like walking, housework or yard work
0❑ Unable to perform any of the above activities due to giving way of the knee

Page 1 Total Points: _____/37

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Page 2 – 2000 IKDC SUBJECTIVE KNEE EVALUATION FORM

SPORTS ACTIVITIES:

8. What is the highest level of activity you can participate in on a regular basis?

4❑Very strenuous activities like jumping or pivoting as in basketball or soccer
3❑Strenuous activities like heavy physical work, skiing or tennis
2❑Moderate activities like moderate physical work, running or jogging
1❑Light activities like walking, housework or yard work
0❑Unable to perform any of the above activities due to knee

9. How does your knee affect your ability to:

		Not difficult at all	Minimally difficult	Moderately Difficult	Extremely difficult	Unable to do
a.	Go up stairs	4❑	3❑	2❑	1❑	0❑
b.	Go down stairs	4❑	3❑	2❑	1❑	0❑
c.	Kneel on the front of your knee	4❑	3❑	2❑	1❑	0❑
d.	Squat	4❑	3❑	2❑	1❑	0❑
e.	Sit with your knee bent	4❑	3❑	2❑	1❑	0❑
f.	Rise from a chair	4❑	3❑	2❑	1❑	0❑
g.	Run straight ahead	4❑	3❑	2❑	1❑	0❑
h.	Jump and land on your involved leg	4❑	3❑	2❑	1❑	0❑
i.	Stop and start quickly	4❑	3❑	2❑	1❑	0❑

FUNCTION:

10. How would you rate the function of your knee on a scale of 0 to 10 with 10 being normal, excellent function and 0 being the inability to perform any of your usual daily activities which may include sports?

FUNCTION PRIOR TO YOUR KNEE INJURY:

	0	1	2	3	4	5	6	7	8	9	10	
Couldn't perform daily activities	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	No limitation in daily activities

CURRENT FUNCTION OF YOUR KNEE:

	0	1	2	3	4	5	6	7	8	9	10	
Can't perform daily activities	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	No limitation in daily activities

Page 2 Total Points: _____/50
(10a is not scored, function prior to knee injury)

Total Points: _____/87

IKDC Score: _____/100