GEORGIA 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	GASTROINTESTINAL	NEUROLOGIC
☐ Fatigue	☐ Abdominal Pain	☐ Restless Legs
☐ Fever	☐ Constipation	☐ Numbness or Tingling
☐ Weight Loss	☐ Diarrhea	☐ Headaches (Migraines)
☐ Weight Gain	☐ Nausea and Vomiting	☐ Dizziness / Lightheaded
EYES	**GENITOURINARY**	☐ Difficulty Walking
☐ Change in Vision	☐ Increased Urination	**PSYCHIATRIC**
☐ Double Vision	☐ Urinating at Night	☐ Depression
☐ Pain	☐ Bloody Urine	☐ Anxiety
EARS, NOSE, THROAT	☐ Pelvic Pain	☐ Irritability
☐ Hearing Loss	☐ Heavy Periods	☐ Thoughts of Suicide
☐ Ear Pain	**MUSCULOSKELETAL**	**ENDOCRINE**
☐ Nose Bleeds	☐ Leg Pain	☐ Frequent Thirst
☐ Sore Throat	☐ Leg Swelling	☐ Frequent Urination
CARDIOVASCULAR	☐ Back Pain	☐ Brittle Hair
☐ Chest Pain	**SKIN**	☐ Crave Ice
☐ Palpitaions	☐ Wounds on Feet	☐ Hair Loss
☐ Prior DVT (Blood Clot)	☐ Skin Changes	**OTHER**
☐ Heart Defect	☐ Skin Rashes or Itching	☐
RESPIRATORY	**HEMATOLOGIC**	☐
☐ Shortness of Breath	☐ Easy Bleeding	☐
☐ Cough	☐ Easy Bruising	☐
☐ Wheezing	☐ Blood Clots	☐

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WESTERN ONTARIO AND
MCMASTER OSTEOARTHRITIS INDEX (WOMAC)

PATIENT NAME

Please circle the appropriate rating for each item.

RATE YOUR PAIN WHEN...	NONE	SLIGHT	MODERATE	SEVERE	EXTREME	OFFICE USE ONLY
Walking	0	1	2	3	4	
Climbing stairs	0	1	2	3	4	
Sleeping at night	0	1	2	3	4	
Resting	0	1	2	3	4	
Standing	0	1	2	3	4	TOTAL
RATE YOUR STIFFNESS IN THE...	NONE	SLIGHT	MODERATE	SEVERE	EXTREME	OFFICE USE ONLY
Morning	0	1	2	3	4	
Evening	0	1	2	3	4	TOTAL
RATE YOUR DIFFICULTY WHEN...	NONE	SLIGHT	MODERATE	SEVERE	EXTREME	OFFICE USE ONLY
Descending stairs	0	1	2	3	4	
Ascending stairs	0	1	2	3	4	
Rising from sitting	0	1	2	3	4	
Standing	0	1	2	3	4	
Bending to floor	0	1	2	3	4	
Walking on even floor	0	1	2	3	4	
Getting in/out of car	0	1	2	3	4	
Going shopping	0	1	2	3	4	
Putting on socks	0	1	2	3	4	
Rising from bed	0	1	2	3	4	
Taking off socks	0	1	2	3	4	
Lying in bed	0	1	2	3	4	
Getting in/out of bath	0	1	2	3	4	
Sitting	0	1	2	3	4	
Getting on/off toilet	0	1	2	3	4	
Doing light domestic duties (cooking, dusting)	0	1	2	3	4	
Doing heavy domestic duties (moving furniture)	0	1	2	3	4	TOTAL

PATIENT SIGNATURE	DATE
REVIEWED BY MEDICAL ASSISTANT	DATE

WOMAC TOTAL SCORE /96 * 100

TEXAS ENDOVASCULAR

WOMAC OSTEOARTHRITIS INDEX QUESTIONNAIRE