



**Medical History**

Steven R. Gecha, M.D.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**Check all that apply:**  Motor vehicle accident  Workman's compensation  Liability/Litigation

**Occupation:** \_\_\_\_\_ **Present work status:**  regular  modified duty  disabled

**Reason for visit:**  R  L knee,  pain  swelling  buckling  other \_\_\_\_\_

Injury Date \_\_\_/\_\_\_/\_\_\_ Describe injury: \_\_\_\_\_

Gradual Onset (estimate start date): \_\_\_/\_\_\_/\_\_\_

No previous problems with R/L knee(s) before present problem

Previous problems with R/L knee(s) \_\_\_\_\_

**Pain:**  **None**

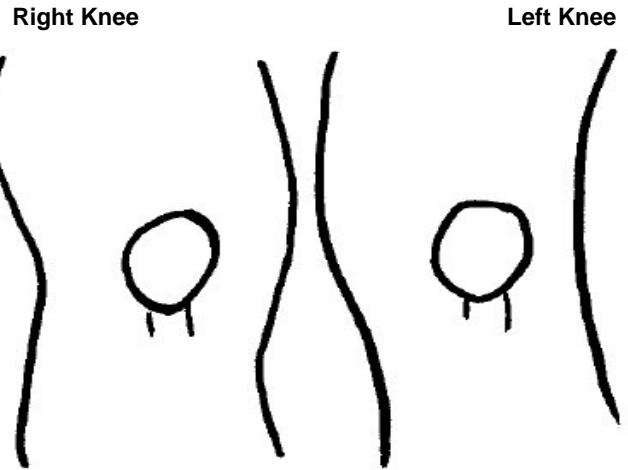
Rate your pain on a scale of 0-10 at its best & worst (0:no pain, 10:debilitating):

1 2 3 4 5 6 7 8 9 10

When do you have pain:

- constant  on/off
- light activity  sports
- at rest  sitting
- at night  stairs ^ v
- squatting  kneeling
- other: \_\_\_\_\_

**Mark location of pain on diagram below:**  
(S: sharp pain, A: ache (dull), B: burning)



**Buckling/giving out:**  **None**

Onset (estimate): \_\_\_/\_\_\_/\_\_\_

How often: \_\_\_ times d / wk / mo / yr

Occurs with:

- walking  running
- stairs ^ v  change of direction
- other: \_\_\_\_\_

**Stiffness / Swelling:**  **None**

Onset (estimate): \_\_\_/\_\_\_/\_\_\_

How often: \_\_\_ times d / wk / mo / yr

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

**Previous treatment:**  **None**

- home exercises  physical therapy
- cortisone injection  synvisc / hyalgan injections
- medications  surgery R / L knee \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_
- other: \_\_\_\_\_

**Previous studies (date):**  **None**

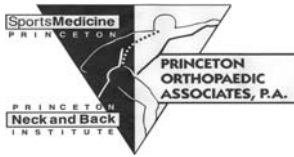
x-rays \_\_\_/\_\_\_/\_\_\_  MRI \_\_\_/\_\_\_/\_\_\_  CAT scan \_\_\_/\_\_\_/\_\_\_  bone scan \_\_\_/\_\_\_/\_\_\_  EMG \_\_\_/\_\_\_/\_\_\_

**Associated symptoms:**  **None**

- numbness  pain shooting down R/L leg
- tingling  weakness R/L leg
- back pain  skin color / temp changes/hypersensitivity
- hip pain  other: \_\_\_\_\_

**Activity level:**

	<u>before problem</u>	<u>now</u>
Very strenuous (jump, pivot - basketball soccer)	<input type="checkbox"/>	<input type="checkbox"/>
Strenuous (heavy work, skiing, tennis)	<input type="checkbox"/>	<input type="checkbox"/>
Moderate (moderate work, run, jog)	<input type="checkbox"/>	<input type="checkbox"/>
Light (walk, house/office work)	<input type="checkbox"/>	<input type="checkbox"/>
Unable to perform above due to knee pain	<input type="checkbox"/>	<input type="checkbox"/>



**Medical History**

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Occupation: \_\_\_\_\_  student  retired  
 Reason for visit: \_\_\_\_\_ Duration of symptoms: \_\_\_\_\_  
 Medical Doctor: \_\_\_\_\_ Location: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Specialist: \_\_\_\_\_ Location: \_\_\_\_\_ Phone #: \_\_\_\_\_

Latex allergy:  yes  no  
 Drug allergies:  yes  no (list medications and type of reaction below):

List all medications & Herbal supplements: (dose, times/day taken:  none

1		6
2		7
3		8
4		9
5		10

**Medical Problems (circle):**

Constitutional
Eyes, cataracts, glaucoma / ears, nose, throat
Lungs, asthma, emphysema, sleep apnea
Heart disease, heart attack, heart murmur
High blood pressure
Blood disorder, anemia, bleeding problem
Diabetes, gout, metabolic disorder, thyroid
Arthritis
Stomach / intestine, ulcer, reflex, irritable bowel
Liver, kidney, gall bladder, hepatitis
Skin
Cancer
Stroke, seizures, Parkinson's, Alzheimer's
Psychiatric

List previous surgeries of hospitalizations:  None Year


**Smoke:**  none \_\_\_\_\_ packs/cig per day, for \_\_\_\_\_ years  
 **Alcohol use:**  none  rarely  socially  daily

**Relation Alive Deceased Medical problems or cause of death**

Father			
Mother			
Siblings			

Height: \_\_\_\_\_ ft \_\_\_\_\_ in  
 Weight: \_\_\_\_\_ lbs  
 R or  L handed

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