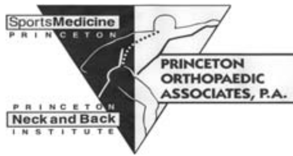


Medical History **Steven R. Gecha, M.D.**

Name: ______________________ Age: ________ Date: ________

Check all that apply: ☐ Motor vehicle accident ☐ Workman's compension ☐ 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

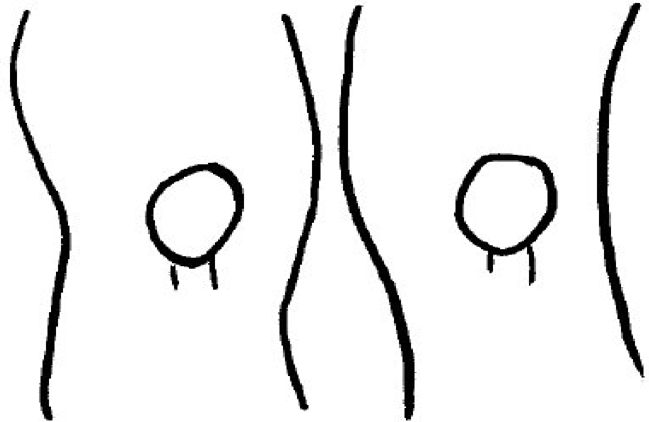
When do you have pain:

- ☐ 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)

Right Knee **Left Knee**



☐ **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:________________________

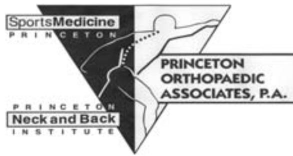
☐ **Previous studies (date):** ☐ **None**

☐ 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:	before problem	now
Very strenuous (jump, pivot - basketball soccer)	☐	☐
Strenuous (heavy work, skiing, tennis)	☐	☐
Moderate (moderate work, run, jog)	☐	☐
Light (walk, house/office work)	☐	☐
Unable to perform above due to knee pain	☐	☐



Medical History **Steven R. Gecha, M.D.**

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:______________