Complimentary Hip and Knee X-ray Review

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Please complete and return this form to Dr. Greenky along with your X-rays for evaluation.

Name: _____

Date of Birth: _____ Age _____

Address: _____

_____

Home Phone: _____ Cell Phone _____

Email Address:_____

Involved hip/knee (circle): right left both

Date symptoms began _____

Night pain? (circle): yes no

Have you ever had surgery on your hip/knee? (circle) yes no
If so, *when* and *what* were the surgeries? (please provide as many details as possible. Use back of sheet if necessary)

_____

_____

What activities cause you to have pain? _____

Are you currently on pain medicines? (circle) yes no

If so, what pain medications: _____

Date of X-ray you are sending: _____

Send this form and any X-rays (along with any available reports) to:

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