

KNEE HISTORY

Name: _____
Last name First name Middle initial

Date: _____

Please answer each of the following questions by checking as many responses as necessary. If the answer you need is not available please feel free to write it in.

How old are you? _____

What is your occupation? _____

Where do you live? (City, State) _____

Who referred you to our office? _____ Previous Patient? ____ Yes ____ No

With which knee are you experiencing difficulty? _____

How long have you been experiencing difficulty with your knee? _____

What do you think may have caused your knee symptoms? (For example: spontaneous, overuse, exercise, specific injury, an accident) Please explain _____

Which of the following knee symptoms are you experiencing? Please check all that apply. Rank them in order of decreasing severity starting with the one (1) as the most significant symptom.

- | | |
|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Popping |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Catching |
| <input type="checkbox"/> Instability | <input type="checkbox"/> Grinding |
| <input type="checkbox"/> Locking | |

Where do you experience the majority of your knee discomfort?

- | | |
|---|--|
| <input type="checkbox"/> Inner side of the knee | <input type="checkbox"/> Back of the knee |
| <input type="checkbox"/> Outer side of the knee | <input type="checkbox"/> Generalized knee pain |
| <input type="checkbox"/> Front or "knee cap" area of the knee | |

Please check the discomfort you are having

- | | |
|----------------------------------|---|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Intermittent |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Present only with certain activities |

Please mark the severity of the knee discomfort that you are having on a scale of 1 to 10 on the line below (1 = minimal, 10 = extremely severe).

_____ 1 5 10
Minimal Moderate Severe

Do you experience discomfort with any of the following motions or activities?

- | | |
|---|---|
| <input type="checkbox"/> Bending the knee | <input type="checkbox"/> Squatting or bending down |
| <input type="checkbox"/> Straightening the knee | <input type="checkbox"/> Sitting for a prolonged period of time |
| <input type="checkbox"/> Going up stairs | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Going down stairs | |

Turn over →

Are you limping? Yes No

Does your knee problem interfere with any of the following?

Daily activities
 Work activities

School activities
 Recreation or sports activities

Please explain: _____

Have you previously had your knee evaluated by?

Primary Care Physician
 Emergency Room Visit

Another Orthopedic Surgeon

Please check any treatments that you have tried for your knee condition

Rest
 Ice application
 Anti-Inflammatory medications (which ones) _____
 Pain medication
 Crutches
 Use of a knee sleeve, wrap or brace
 Immobilization
 Cortisone injection
 Physical therapy
 Other _____

Has the treatment helped?

Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No

Have you ever had knee surgery in the past? Yes No

If yes, please explain (date, doctor, procedure if known) _____

Have you had any of the following imaging studies for your knee?

X-Ray
 MRI
 Arthrogram

CT scan
 Bone scan
 Other _____

How is your knee progressing?

Getting better Getting worse Staying about the same

Have you ever had any other significant knee injury in the past? Yes No

If yes, please explain _____

If yes, did you recover fully? Yes No

Please list any other information you feel would assist your doctor with your treatment.

