

KNEE HISTORY

NAME: _____ DATE: _____
Last Name First Name Middle Initial

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? _____ Is the referring person a previous patient? ____ Yes ____ No

With which knee are you experiencing difficulty? ____ Right ____ Left ____ Both
____ Right worse than left
____ Left worse than right

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

On what date did your symptoms begin (if known)? _____

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

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

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

Where do you experience the majority of your knee pain?

- | | |
|---|---|
| <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 pain throughout the knee |
| <input type="checkbox"/> Front or "knee cap" area of the knee | |

Please check all that apply to your knee discomfort:

- | | |
|----------------------------------|---|
| <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 your knee discomfort on a scale of 1 to 10 on the line below



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

- | | |
|---|---|
| <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 | |



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Are you limping? Yes No

Does knee problem interfere with any of the following?

Daily activities

Work activities

School activities

Recreation or sports activities

Please explain: _____

Do you experience knee pain at night which interferes with your sleep? Yes No

Have you previously had your knee evaluated by:

Primary care physician

Another orthopedic surgeon

Emergency room visit

Have you had any of the following imaging studies for your knee? Please include dates, if known.

X-ray

MRI

CT Scan

Bone Scan

Other _____

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

Rest

Ice application

Anti-inflammatory medications (Which medications) _____

Pain Medication (Which medications) _____

Cortisone injection (Date) _____

Immobilization/ brace

Physical therapy

Other _____

Has treatment helped?

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

Yes No

How is your knee progressing? Getting better Staying the same Getting worse

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

If yes, please explain: _____

If yes, did you fully recover Yes No

Have you ever had knee surgery Yes No

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

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

