Knee Questionnaire

Name: ____________________________________  Age: ______  Weight: ________

Which knee(s) bothers you?  Right  Left

How long has this been going on?  ____________________________________________

Do you know what caused the problem?  If yes, describe: ____________________________________________

Did you ever injure the knee?  If yes, when: ____________________________________________
And how: __________________________________________________________________________

Have you ever had surgery or arthroscopy on your knee?  Right  Left
If yes, when and where?  ____________________________________________
Describe: __________________________________________________________________________

Have you had any x-rays _____, CAT scan (CT) _____, Ultrasound _____, MRI _____ of your knee?  Right  Left
If yes, when and where?  ____________________________________________
Did you submit any of the above exams for comparison?  Yes  No
If no, can you submit these for comparison to today’s exam?  Yes  No

If you have knee pain, describe it: (check all that apply)
Dull          Aching         Sharp
Constant     Intermittent
Pain with walking up or down stairs  Yes  No
Pain with bending knee  Yes  No
Pain with jumping  Yes  No
Pain with other activity (describe) __________________________________________________________________________

Location of pain:
Front          Back          Inner aspect
Outter aspect

How bad is the pain? (on a scale from 1 to 10, where 1 = minimal pain, 10 = terrible pain)

Does your knee ever-
pop or click?  Yes  No
give out or buckle?  Yes  No

Does your knee ever swell up?  Yes  No
If yes how often?
-Once every:  Day  Week  Month  Year
-Only after exercise

Did you ever dislocate your patella?  Yes  No  Not sure

Did you ever fracture your knee?  Yes  No  Not sure

Do you exercise or play sports?  If yes, describe: ____________________________________________

Do you take any medications for your knee problem?  If yes list: ____________________________________________

Do you have history of any cancer?  If yes describe: ____________________________________________

Please add anything else that you think might be important: ____________________________________________

List any other medications, medical problems or surgeries: ____________________________________________

Medicine allergies ____________________________________________
Latex allergies ____________________________________________
Using the figures, please shade in the areas affected by pain and/or numbness. Please be precise.