Orthopedic Patient Questionnaire: KNEE

Name: ______________________________ Gender: ☐ Male ☐ Female

1. Which knee is bothering you? ☐ Right ☐ Left ☐ Both | Which one hurts worse? ☐ Right ☐ Left

2. Were you injured? ☐ Yes ☐ No How were you injured? ______________________
   Where: ☐ Work ☐ Home ☐ Other: ______________

3. Prior injuries or problems to your knee? ☐ Yes ☐ No When: ______________
   How were you injured? ______________________
   Who treated you? ______________________

4. Prior treatment for this injury? ☐ None ☐ Emergency Room | Hospital: ______________
   ☐ Doctor's office | Name: ______________

5. What was done? X-rays: ☐ Regular x-rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Other: ______________
   Medication: ☐ Anti-inflammatory ☐ Pain meds ☐ Cortisone shot
   Devices: ☐ Ace wrap ☐ Knee immobilizer ☐ Brace ☐ Splint ☐ Cast
   Physical therapy: ☐ Yes ☐ No If yes, how long? ______________

6. Prior surgery to this knee? ☐ Yes ☐ None ☐ Arthroscopy ☐ Cartilage Tear ☐ ACL Tear ☐ Fracture

7. Any back pain? ☐ Yes ☐ No
8. Tingling down your legs? ☐ Yes ☐ No
9. Pain is *always* present? ☐ Yes ☐ No
10. Pain **without** motion of leg? ☐ Yes ☐ No
11. Loss of motion of knee or swelling? ☐ Yes ☐ No
12. Popping/catching of knee? ☐ Yes ☐ No
13. Pain on (circle) ☐ **inside** ☐ **outside** ☐ **back** of knee
14. Weakness of the leg? ☐ Yes ☐ No
15. Burning down your legs? ☐ Yes ☐ No
16. Pain comes and goes away? ☐ Yes ☐ No
17. Pain with motion of leg? ☐ Yes ☐ No
18. Pain wakes me up at night? ☐ Yes ☐ No
19. Locking of knee area? ☐ Yes ☐ No
20. Pain (circle) ☐ **squatting** or ☐ **stair climbing**
21. Any knee cap pain? ☐ Yes ☐ No
22. Does your knee give way? ☐ Yes ☐ No

23. Do you take medication or anti-inflammatory medicine? ☐ Yes ☐ No Type: ______________
    Number of pills an average per day? __________ pills.

24. How bad is your pain today? (no pain) 0 ———— 5 ————10 (worse pain)

25. Does your knee feel unstable (as if it were going to dislocate)? ☐ Yes ☐ No
    How unstable is your knee today?(Mark line) (stable) 0 ———— 5 ————10 (very unstable)

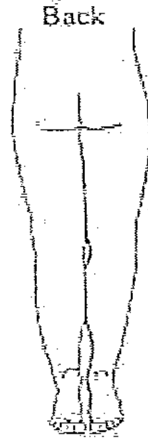
PATIENT LABEL

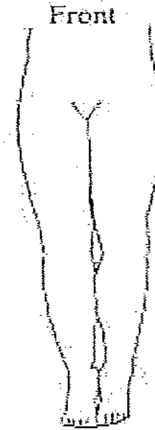
26. Mark on the diagram the location of pain or sensation.

Pain starts ——▶ Stops here X

Sensation type:

////////	Sharp stabbing
AAA	Aching
═══	Numbness
CCC	Catching
++++	Burning
PPP	Popping
*****	Pins & needles





Please return to receptionist when complete.

Patient Signature ______________________ Date ______________

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If other than the patient, indicate relationship

______________________ M.D./P.A.
Provider Signature

PATIENT LABEL