PATIENT QUESTIONAIRE

NAME ______________________ **AGE:** ____________ **TODAY'S DATE:** ____________

PLEASE CIRCLE THE ANSWERS THAT BEST DESCRIBE YOUR PROBLEM

PROBLEM WITH: (L) KNEE (R) KNEE BOTH KNEES

ONSET OF PROBLEM

Gradual

Accident:

Sports - Date:

Work - Date:

Other________

LOCATION OF PAIN

Inner side Outer side

Knee cap All over

FREQUENCY OF PAIN

Occasional Constant

Wakes you at night

PAIN MADE WORSE BY

Twisting Walking

Sitting Running

Physical therapy

KNEE GIVES OUT OR BUCKLES (GIVES AWAY)

Never Often

While walking

While on stairs

While pivoting

SWELLING

None

Occasional

Does not go away

Only with activity

AIDS TO WALKING

Cane

Crutches

Walker

Wheelchair

PRIOR INJURY

Yes No

OFF WORK

Yes No

HOW LONG:

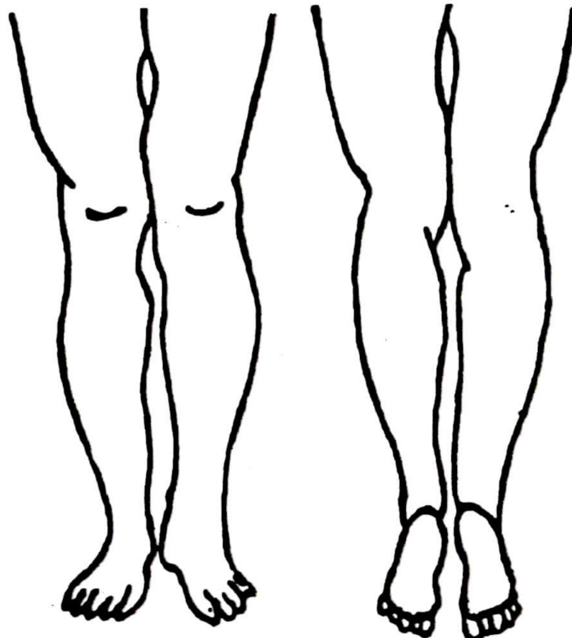
____

DESCRIBE ACCIDENT

____

____

PLEASE MARK IN AREAS OF PAIN



PRIOR TREATMENT

Have you ever had knee surgery:

Yes No

LIST MEDICATIONS YOU HAVE TAKEN FOR YOUR KNEE:

____

____

HAVE YOU EVER HAD AN INJECTION IN YOUR KNEE: Yes No

MOBILITY (LIMP)

Limp No Limp Can't run

GRATING OR GRINDING (CLICK)

None

Notice it on stairs

While walking

LOCKING (GETTING STUCK)

None Often Occasional

POSITION OF KNEE

Becoming more bowlegged

Becoming more knockkneed

ACTIVITIES

Unable to work

Housebound

Unable to care for self

Unable to participate in sports or recreation

HOW FAR CAN YOU WALK

1 Block 1 Mile

2 Blocks 2 Miles

3 Blocks