

Patient Questionnaire: Knee

Name: _____ Age: _____ Date: _____ Acct.# _____

Which knee has pain? Right Left Both

When did your present pain start (approximately what date)? _____

Was there a related injury/accident? Yes No Please explain _____

Please describe how your pain started: No apparent cause

Have you had similar pain in the past? Yes No If yes, when? _____

Where is the pain located? Inside Outside Front Back
Please indicate how severe your pain is now (0=no pain to 10=worst pain) _____

Which of the following activities produces pain?

stairs squatting kneeling pivoting sitting getting up

walking How far can you walk before needing to rest? _____

Other _____

Which of the following symptoms do you have?

locking clicking swelling giving way none

Which of the following treatments have you used?

ice/heat NSAIDS (Motrin, Aleve, Celebrex) Tylenol physical therapy

Glucosamine/chondroitin sulfate Cortisone Injection

How much relief was provided? _____ How long did it last? _____

Do you use any of the following assistive devices?

brace crutches cane walker

Name: _____ Age: _____ Date: _____ Acct.# _____

Medical History None Height: _____ Weight: _____

High Blood Pressure Diabetes Hypothyroidism Coronary Art Disease

Angina/MI Arrhythmia COPD Emphysema Asthma

Renal Failure Ulcers Cancer Arthritis SLE (lupus)

Rheumatoid Arthritis Seizures Clots (DVT) Blood Disorders

Other _____

Surgical History (including dates): None

Current Medications None

Allergies None

Do you have difficulty taking Antiinflammatory medications? Yes No

Social History

Tobacco use: Yes No if yes, packs per day _____ and years of use _____

Alcohol use: Yes No if yes, amount per week _____

Job description/School Attending: _____

Work Status: Are you Employed Unemployed Disabled Retired?

Marital Status _____ # of children _____

Family History

Please list any significant medical problems in your family

Name: _____ Age: _____ Date: _____ Acct.# _____

Review of Systems

Check all that apply to your health

Constitutional

- Fever, Chills, Sweats
- Weight loss
- Change in appetite
- Excessive fatigue
- None of the above

Eyes, Ears, Nose, & Throat

- Recent changes in vision
- Glaucoma
- Metal fragments in eyes
- Nosebleeds
- Hearing loss
- Poor balance
- None of the above

Cardiovascular

- Chest pain or Angina
- High blood pressure
- Heart murmur
- Irregular pulse
- Elevated Cholesterol
- Calf pain when walking
- None of the above

Respiratory

- Sleep apnea
- Asthma, wheezing
- COPD
- Chronic cough
- Blood in sputum
- Lung Cancer
- Pneumonia or bronchitis
- None of the above

Gastrointestinal

- Ulcer or gastritis
- Nausea or vomiting
- Jaundice or liver problems
- Gallbladder problem
- GERD/heartburn
- Blood in stool
- Colon Cancer
- None of the above

Genitourinary

- Bladder infections
- Blood in urine
- Difficulty with urination
- Kidney stones
- Prostate problems
- Abnormal Pap smear
- None of the above

Musculoskeletal

- Swelling in multiple joints
- Excessive flexibility of joints
- Broken bones, which? _____
- Dislocated joints, which? _____
- Fibromyalgia
- Reflex Sympathetic Dystrophy
- None of the above

Skin

- Chronic rashes
- Eczema or Psoriasis
- Skin Cancer
- Breast lump/nipple discharge
- None of the above

Neurological

- Seizures
- Leg pain/sciatica
- Weakness of a limb
- Numbness of a limb
- Bowel/bladder control loss
- Stroke
- Loss of memory
- None of the above

Psychiatric

- Anxiety
- Depression
- Claustrophobia
- None of the above

Endocrine

- Diabetes
- Thyroid problems
- Hormone Replacement Therapy
- Taken Prednisone
- Anemia
- None of the above

Hematological/Immunology

- Easy bleeding/bruising
- Blood transfusions
- Decreased resistance to infection
- None of the above