

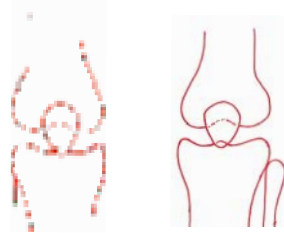
PAGE ONE TO BE FILLED OUT BY PATIENT

NAME: _____ AGE: _____ SEX: M/F DATE: __/__/__ Refer MD: _____
 Occupation: _____

Affected Knee (please circle):	Right	Left	
Do you have pain?	Yes	No	If yes, for how long?: _____
Did you have a specific injury?	Yes	No	If yes, when? Date: _____
Have you had recurrent injuries?	Yes	No	If yes, how many?: _____
Did you injure your knee playing sports?	Yes	No	If yes, sport?: _____
Does or has your given out?	Yes	No	If yes, number of times: _____
Does your knee swell?	Yes	No	
Has your knee been injected?	Yes	No	With what? _____
Did the injections help?	Yes	No	If so, for how long? _____

Please describe the injury and activity at the time of the original injury and currents symptoms: (use the back if necessary)

Do you have pain going up or down stairs, or squatting?	Yes	No	Right	Left
Do you have pain in the front of the knee?	Yes	No		
Do you have pain on the inside of the knee?	Yes	No		
Do you have pain on the outside of the knee?	Yes	No		
Do you have pain in the back of the knee?	Yes	No		
Does your knee feel stiff after sitting?	Yes	No		
Does your knee lock?	Yes	No		
Does your knee give out or feel unstable?	Yes	No		



What medications are you taking for your pain?

_____	Yes	No
Have the medications helped?	Yes	No
Have you done physical therapy for your knee?	Yes	No
Have you had knee surgery?	Yes	No
If yes, please describe what was performed and when:	_____	

Do you walk with: (check one) No Crutches or Cane Crutches Cane Walker
 How far can you walk? Unlimited Less than 1 block 1-5 blocks 5-10 blocks Unable

Do you have any numbness or tingling? Yes No If yes, where: _____