

KNEE HISTORY

Name _____ Date ____/____/____

Last grade of school completed _____ Age _____ Ht _____ Weight _____

Currently Working? Yes No Retired If yes, type of work _____

PRESENT COMPLAINT: (check one) RIGHT KNEE LEFT KNEE

Is present problem related to Injury? Yes No If yes, when _____

Describe injury: _____

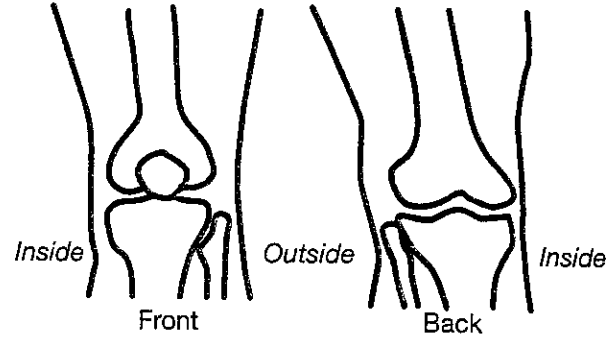
Where? Athletics At Work Home Vehicle Other: _____

Do you have pain: Yes No Grade your pain: 1 2 3 4 5 (1 = minor 5 = Severe)

Do you have any of the following:

	RIGHT KNEE		LEFT KNEE	
Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Locking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking / Popping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grating / Grinding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Giving Way	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Locate your pain: RIGHT KNEE LEFT KNEE



Is your pain increased by: Walking Standing Running Jumping Lifting Other: _____

Is your pain decreased by: Walking Standing Running Jumping Lifting Other: _____

Are you able to: Walk Yes No
 Work Yes No
 Play sports Yes No
 Run Yes No
 (_____ blocks; _____ miles)
 Full time Part time

Have you been treated previously? If yes, when _____ Where _____

	RIGHT KNEE		LEFT KNEE	
When	_____	_____	_____	_____
From Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Describe: _____

Where? Athletics At work Home Vehicle Other: _____

How was the prior problem treated? **RIGHT KNEE** **LEFT KNEE**

Dates	RIGHT KNEE		LEFT KNEE	
No treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthroscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Open Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments: _____