Name:
Chart:
Date:

KNEE HISTORY

Name _____ Date of Birth _____

Is this examination for your _____ right knee, _____ left knee or _____ both knees?

Is this problem due to any of the following?

_____ Auto accident
_____ Falling
_____ Motorcycle accident
_____ Snowmobile accident/ATV accident
_____ Sports Injury
_____ Work related

_____ Other, please state _____

BRIEF HISTORY OF ONSET AND DURATION OF KNEE PROBLEM: _____

_____

If you are having pain, please check all that apply:

_____ Daily pain (limits normal daily activities)
_____ Night pain
_____ Pain limiting sleep
_____ Lower extremity numbness or tingling

PLEASE CIRCLE EACH ANSWER.

Do you have knee pain in the morning? YES NO
Do you have knee stiffness in the morning? YES NO
Do you have swelling in your knee? YES NO
Have you had any swelling in your knee in the past? YES NO
If yes, please state when this occurred _____
Have you had any swelling in other joints? YES NO
Do you have pain in your (please circle) hip, low back, groin region?
Do you have pain in your knee when _____ walking, _____ running, _____ sitting or _____ standing for prolonged periods of time?
Do you use _____ cane, _____ walker, _____ crutches? If yes, how often? _____
Do you have pain on climbing stairs? YES NO
Do you have a grinding sensation in your knee? YES NO
Do you have a clicking sensation in your knee? YES NO
Do you have a feeling of giving way in your knee? YES NO
Does rainy weather bother your knee? YES NO
Does activity make it (please circle) better or worse?
Do over the counter pain medications relieve the pain or ache in your knee? YES NO
If yes, which _____
Can you fully straighten your knee? YES NO
Have you had a previous injury or problem with your knee? YES NO
If yes, please state how this occurred, date and treatment _____

_____

Are you on any medications at the present time for this problem? YES NO
If you, please state _____
Have you attempted any weight loss as treatment for this problem? YES NO
Have you tried a brace or other knee support? YES NO
Has physical therapy or therapeutic exercise been attempted? YES NO

If you have seen another physician for this problem, please name _____

If you have been off work because of this problem or injury, please give the date last worked _____

Other history or information, please use reverse side if more room or further communication is needed: _____

_____

_____