ORTHOPAEDIC - KNEE QUESTIONNAIRE

Today's Date ____________ Height (feet/inches) ____________ Weight (pounds) ____________

First Name ____________ Last Name ____________

Date of Birth ____________ Age ________ Occupation ____________ Gender: ☐ Male ☐ Female

HISTORY

Which knee is causing the problem? ☐ Right ☐ Left ☐ Both

When did your symptoms begin? ____________

Did you have an injury? ☐ Yes ☐ No If yes, when did the injury occur? ____________

How did the injury occur? ____________

____

Was the injury work related? ☐ Yes ☐ No ☐ Not Sure

Where is your knee pain located? ☐ Front ☐ Back ☐ Inside ☐ Outside ☐ Under Kneecap

What best describes the pain? ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Constant ☐ Activity Related

What activities aggravate your knee? ☐ Walking ☐ Kneeling ☐ Squatting ☐ Pain at Rest ☐ Pain During Sleep ☐ Twisting ☐ Running ☐ Sports

Do you experience any of the following? *(Check all that apply)*

☐ Swelling ☐ Grinding ☐ Non-Painful Noises
☐ Popping ☐ Catching ☐ "Locking" (suddenly cannot move knee; too painful)

How many minutes can you walk without pain? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+

How far can you walk before stopping due to pain? ____________

Are stairs difficult for you? ☐ Yes ☐ No

If yes, do you walk using a handrail? ☐ Yes ☐ No

If yes, do you walk one stair at a time? ☐ Yes ☐ No

How does your knee limit your activities? ____________

What makes your knee feel better? ____________

What treatment have you tried?

☐ Medication *(please list below)* ☐ Physical Therapy ☐ Cortisone Injection
☐ Synvisc ☐ Activity Modification ☐ Surgery *(please list below)*

If you checked "Medication", please list pain medications you have been taking. Please include dosages and frequency.

Name of Medication	Dose	Frequency

If you checked "Surgery", please list the type of surgery, name of the surgeon, and date you had surgery:

Surgery	Physician	Date

Please list tests done to evaluate your problem:

Test	#1 Date	Where?	#2 Date	Where?
Knee X-Ray				
MRI				

OFFICE USE ONLY. TO BE COMPLETED BY YOUR PROVIDER.

Height ____________ Weight ____________

	Right / Left
ROM	______ / ______
Effusion	______ / ______
Crepitus	______ / ______
Extensor Lag	______ / ______
Atrophy	______ / ______

LIGAMENT EXAM:

	Right / Left
Lachman's	______ / ______
Posterior Drawer	______ / ______
Varus	______ / ______
Valgus	______ / ______
Pivot Shift	______ / ______

PATELLA:

	Right / Left
Apprehension	______ / ______
Compression	______ / ______
Glide	______ / ______

MENISCUS:

	Right / Left
Medical Joint Tenderness	______ / ______
Lateral Joint Tenderness	______ / ______
Meniscus Compression	______ / ______

Patient Signature: ______________________ Date: ____________

Provider Signature: ______________________ Date: ____________