KNEE QUESTIONNAIRE

X-Ray # _____

Name _____ Date of Exam_____ Chart # _____

Which Knee? (L) _____ (R) _____ Occupation_____

If injured, date of injury_____ If not injured, date of onset of symptoms_____ Duration of symptoms_____

Is this injury due to an accident? ☐ Yes ☐ No An on the job injury? ☐ Yes ☐ No Related to a motor vehicle accident? ☐ Yes ☐ No

Please write a description of your injury and/or symptoms in the space provided below:

Please mark the boxes that apply:

DO YOU HAVE	YES L	YES R	ONLY WITH ACTIVITY	RARELY	WEEKLY	DAILY
LOCKING						
GIVING WAY						
CATCHING						
SWELLING						
PAIN AT NIGHT						
MORNING STIFFNESS						
CLICKING						
POPPING						
GRINDING						
CHANGES WITH WEATHER						

Please mark the boxes that apply:

DIFFICULTY WITH:	YES L	YES R
STAIR/HILLS		
UNEVEN TERRAIN		
RUNNING		
CUTTING (changing direction)		
KNEELING		

Do you consider your symptoms: (Circle one) Annoying Inconvenient Restricting Disabling

Past history of knee problems: yes ☐ no ☐ (If yes, please explain)

Any prior knee surgery: Procedure _____ Which Knee? _____

When? _____ Where? _____ Doctor's Name _____

Have you seen another physician for this injury?_____ When? _____ Dr. Name _____

Is this appointment for a second opinion? _____ Name of doctor you saw for initial opinion _____

All medications you have taken for this injury (include over the counter medications)_____

Have you had any physical therapy for this injury? (this would include home therapy or formal therapy) _____

Are you currently out of work or on limited duty due to this injury/problem? _____ Do we need to address duty status today? _____

Please sign your name_____ Date_____