Orthopedic Specialty Associates
New Patient Questionnaire - Knee

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Name: _____ DOB (age): ___ / ___ / _____ (___) Date: ___ / ___ / _____

Primary Care Physician (PCP): _____ Occupation: _____

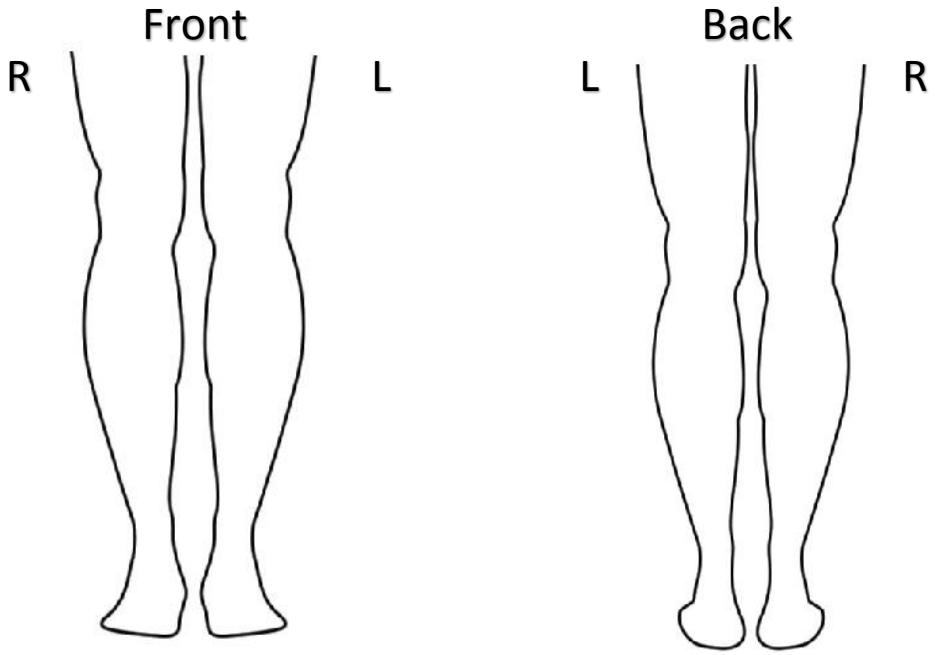
Referred by (circle one): Physician Family/friend Athletic Trainer Coach Internet Other: _____

Injured knee: Right Left Both

Nature of Symptoms

Location: use arrows or shade all areas of pain

Worst pain: place an "x" where **most** of your pain is or where your pain **originates**



Pain Level: _____ / 10

Date that symptoms began: ____ / ____ / _____

Was there a specific injury that occurred? Yes No Unsure

If yes, briefly explain: _____

Are your symptoms getting: Better Worse Staying the same Unsure

Have you previously injured or had surgery on the involved knee? Yes No Unsure

If yes, briefly explain: _____

Have you had previous treatment to the involved knee related to a previous injury? Yes No Unsure

If yes, briefly explain: _____

Is your pain: Constant Intermittent Associated with activity Easily reproducible

Is your pain: Sharp Dull Achy Throbbing Numbing Tingling Radiating Other: _____

Do you experience: Popping Clicking Catching Locking Grinding Instability Giving way (painful? Y N)

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New Patient Questionnaire – Knee cont.

Is your pain aggravated by: Prolonged walking / standing / sitting Ascending stairs Descending stairs Running Cutting Pivoting Crossing legs Getting up from sitting Deep knee flexion Squats Kneeling

Is your pain aggravated by sports or recreational activity: Yes No

If yes, describe aggravating activities: _____

Please list any other activities or positions that aggravate your pain: _____

_____

Do you have pain at night? Yes No **Does it keep you up at night/wake you up at night?** Yes No

If yes, when? Laying on the involved leg Laying on uninvolved leg Any position

Have you noticed swelling in or around your knee? Yes No Unsure

If yes, has it: Increased Decreased Unsure

Has your kneecap ever dislocated or popped out of place? Yes No Unsure

If yes, when? How many times? _____

Previous Treatment for Current Injury

Rest: Yes No

Injections: Yes No Unsure

If yes: How many? _____ Most recent: _____ Did it help? _____

Physical Therapy: Yes No Unsure

If yes, how long? _____ Therapist name & location: _____

Other treatment: _____

Previous Imaging on Involved Extremity

X-rays: Yes No If yes, when? _____ Where? _____

MRI: Yes No If yes, when? _____ Where? _____

CT Scan: Yes No If yes, when? _____ Where? _____