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Board Certified Orthopaedic Surgery
Board Certified Sports Medicine

Knee-Patient Evaluation Form

Name:_____ Chart #:_____

Age:_____ Sex:_____ Which Knee:_____

How long have you had these symptoms:_____ Date:_____

Date this problem began:_____

1) My primary complaint is (Check all that apply):
   ___ pain ___ dull ache ___ loss of motion
   ___ swelling ___ grinding
   ___ giving out ___ locking
   ___ other (Please explain)_____
2) Did this problem start (Check all that apply):
   ___ gradually ___vehicle accident
   ___ suddenly ___ don't know
   ___ while playing sports-which sport_____
   ___while at work

IF YOU HAVE BEEN EXPERIENCING PAIN, PLEASE ANSWER THIS SECTION. If not, please go on to question 8.

3) The primary location of pain is (Check all that apply):
   ___ knee cap ___throughout the knee ___outer side
   ___ back ___ inner side ___deep inside
4) When does the affected knee hurt? (Please check one.)
   ___infrequently
   ___constantly
   ___when active
   4a) Does the affected knee hurt when you are resting? ___ yes ___ no
5) Does the pain in the affected knee occur at night? ___ yes ___ no
   5a) When pain occurs at night, does it awaken you? ___ yes ___ no
6) When is the pain made worse? (Check those that apply.)
   ___ sitting ___ standing ___ walking ___climbing stairs
   ___ getting up ___running ___ during physical exercise
7) The pain is relieved by: (Check all that apply.)
   ___ nothing ___ rest ___moving the knee
   ___ heat therapy ___ activity
   ___ cold therapy
   ___ medicine-if so, what kind?_____

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8) Is the affected knee ever swollen? (Check all that apply.)
___ Never ___Only after exercise or use
___ Infrequently ___At the time of the original injury, but not since then
___ Constantly

9) Are there any grating or grinding noises or sensations in the joint? (Check all that apply.)
___ None ___When climbing stairs
___ When getting up from a chair ___When descending stairs
___ When walking ___When I do deep knee bends

10) When does your knee lock (get stuck)?
___ Never ___At first, not now
___ Frequently or occasionally ___Continually

11) When knee gives out or buckles, it feels like: (Check all that apply.)
___ This does not apply ___ Knee cap shifts
___ Entire knee shifts ___ Something inside the knee shifts

12) What is the range of motion in your affected knee?
___ Same as ever
___ Unable to fully straighten the joint
___ Unable to fully bend or flex the joint

13) Mobility of the joint: ___ Able to walk normally ___ Walk with a limp

14) What activities are you unable to do? (Check all that apply.)
___ walk-how far? ___ ½ block ___less than ½ mile
___1 block ___greater than ½ mile
___ Climb ___ Jump ___ Squat ___ Run ___ Not affected

15) Are you using walking aids?
___ None ___ Cane ___ Crutches
___ Wheel chair ___ Brace ___ Walker

16) Were you treated by a physician for this problem? ___yes ___no
Doctor: _____
Address: _____
Diagnosis: _____
Treatment: _____
Type of Doctor: _____

17) Were you treated at an emergency room for this problem? ___yes ___no
Hospital: _____
Address: _____

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18) Did you have X-rays taken for this problem? ___yes ___no

Date	Location	Results
_____	_____	_____
_____	_____	_____

19) Did you have an arthrogram (dye test)? ___yes ___no

If yes, please list below:

Date	Location	Results
_____	_____	_____
_____	_____	_____

20) Did you have an arthroscopy or arthroscopic surgery performed on the affected knee (looking into the joint)?

___yes ___no **If yes, please list below:**

Date	Location	Results
_____	_____	_____
_____	_____	_____

21) Did you have an open surgery on the knee joint? ___yes ___no **If yes, please list below:**

Date	Doctor	Type	Results	Complications
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

22) Do you have any of the following medical problems

___ Heart disease
___ High blood pressure
___ Lung disease
___ Diabetes
___ Rheumatoid arthritis
___ Other arthritis
___ Inherited disease
___ Gout
___ Stomach ulcer
___ Bleeding tendency
___ Circulatory problems
___ Cancer
___ Other (Please describe): _____

_____

23) Have you been under a doctor's care in the last two years? ___yes ___no

If yes, please list below:

Doctor:_____ Address:_____

Reason:_____

24) What medications are you currently taking?

Medication	Dosage
_____	_____
_____	_____
_____	_____

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25) Have you taken any of the following medications within the past six months?

Cortisone pills or shots	___yes	___no
High blood pressure pills	___yes	___no
Water pills	___yes	___no
Heart medicine	___yes	___no
Insulin	___yes	___no

26) Please list all known allergies and your reaction:

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

27) Please list any major surgeries you have had along with any complications that may have occurred:

Surgery	Complications
_____	_____
_____	_____
_____	_____
_____	_____

28) Please rate the overall level of physical health:

___ Excellent
___ Very good
___ Good
___ Fair
___ Poor

Height: _____ Weight:_____

Right handed _____ Left handed_____ Both _____

Do you smoke? ___yes ___no

29) Who referred you to us for this evaluation and care?

___ Physician ___ Trainer
___ Former patient ___ Found the office in the yellow pages
___ Coach ___ Word of mouth (includes other patients)