

Date: _____

Age: _____

Patient Name: _____

Date of Birth _____

Referring Physician: _____ Primary Physician _____

Problem with: RIGHT KNEE LEFT KNEE Estimated date first noticed problems: ____/____/____

Was this due to injury? Yes No Was injury work related? Yes No

Currently working? Yes No How did injury occur : _____

Prior Knee Surgery? Yes No If yes, list date, procedure and doctor _____

How would you rate your worst pain? 1 (No pain), 2, 3, 4, 5, 6, 7, 8, 9 and 10 (severe pain)

Problem is presently: Worsening Unchanged Improving

The pain is? Constant Intermittent

Location? Medial (inner thigh) Lateral (outer side) Anterior (front)
 Diffuse (all over) Posterior (back)

Quality? Sharp Dull Burning Throbbing
 Tingling Electric Shocks

Other Complaints? Locking Giving way Night Pain Pain with stairs Stiffness
 Grinding/Popping Swelling Weakness Other _____

Activities which were interfered with include:

- Sports Walking Shopping Stair Climbing Kneeling Squatting Running
 Sleeping Gardening Working During Exercise After Exercise Rising from a chair
 Other _____

Treatments that have been tried include:

- Anti Inflammatory _____ Helped? Not Helped Physical Therapy Helped? Not Helped
 Pain Medications _____ Helped? Not Helped Crutches/Cane/Walker Helped? Not Helped
 Exercises Helped? Not Helped Bracing Helped? Not Helped
 Reduced Activity Helped? Not Helped Knee Injection Helped? Not Helped
 Knee Drained Helped? Not Helped MRI Other _____

Review of Systems: Please check all that apply for you

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thalassemia/Von Willebrands |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Emphysema/Chronic Bronchi | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Heart Valve Disease | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Stomach Ulcer/Reflux |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Ulcerative Colitis/Chron's |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Depression/Bipolar Disorder | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Psoriasis or Skin Disease |
| <input type="checkbox"/> TIA | <input type="checkbox"/> Seizure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Asthma/Tuberculosis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Adrenal/Pituitary Disease | <input type="checkbox"/> COPD |

Cancer, which type/where? _____ Treatment _____

Diabetes, controlled with: Insulin Oral Medication Diet

None of the above _____ Other _____

SECOND OPINION _____

Family History	Yes?	Relationship	Family History	Yes?	Relationship
Arthritis (Specify type)			High Blood Pressure		
Bleeding Problems			Congenital Heart Disease		
Cancer (Specify)			Leukemia		
Diabetes			Liver Disease		
Emotional Problems			Stroke		
Epilepsy/Seizures			Suicide		
Heart Disease			Tuberculosis		