

NEW PATIENT KNEE QUESTIONNAIRE

NAME: _____ **AGE:** _____ **DATE:** _____

Please Circle One:

RIGHT KNEE

LEFT KNEE

BOTH KNEES

How long has your knee(s) bothered you? _____

Is this an injury? YES or NO

Date of injury: _____

How injury occurred: _____

Have you seen other physicians for this? YES or NO

(If yes, please list) _____

What treatments have you had? Please include self treatment.

NONE

MEDICATIONS (list) _____

BRACE

PHYSICAL THERAPY

HOME EXERCISE PROGRAM

Does your knee:

Y or N POP

Y or N CLICK

Y or N SWELL

Y or N GIVE OUT

Y or N CATCH

Y or N GET STIFF AFTER SITTING

Y or N WAKE YOU UP AT NIGHT BECAUSE OF PAIN

PLEASE USE GRAPH BELOW TO DEMONSTRATE WHERE YOUR KNEE HURTS

