KNEE QUESTIONNAIRE

Patient Name: _____

DOB: _____

Date: _____

1. What happened to your knee? _____

   _____

   _____

2. Which knee is it? [ ] Left [ ] Right
3. Please give the date of your injury: _____

   Or is it: [ ] **ONGOING PAIN**
4. How long have you had pain? _____
5. Do you have swelling? [ ] YES [ ] NO
6. Does your knee lock or catch? [ ] YES [ ] NO
7. Does your knee feel unstable? [ ] YES [ ] NO
8. What treatment have you had in the past? _____

   _____

   _____

9. Are you: [ ] BETTER [ ] Worse [ ] SAME since your treatment began?
10. Have you ever had any x-rays of your knee? [ ] YES [ ] NO
11. Have you ever had any surgerydone on your knee? [ ] YES [ ] NO
12. Have you ever had fluid removed from your knee? [ ] YES [ ] NO

    If so, how many times? _____
13. What athletic activities do you participate in? _____

    _____

    _____

14. Have you ever had blood clots in your veins? [ ] YES [ ] NO
15. Do you have any problems with your hip or ankle? [ ] YES [ ] NO

    If so, please describe: _____

    _____