Knee Evaluation

Please be as complete as possible and print clearly

Name:____ Today's Date___/___/___ Age:_____ Height:________ Weight:__________

Occupation:____ Family Physician:____

Who referred you to this office?____

Involved Knee: Right Left Bilateral

HISTORY OF INJURY

Did you have an injury to your knee? Yes No

When did the injury occur or when did *the symptoms* begin (day, month, year)?____

How did the injury occur?____

____

Do you have Pain Loss of motion Swelling Burning or numbness

Mechanical Symptoms (feels like there's a pebble in your knee)

Instability of buckling

Location of your knee pain: Front of knee (kneecap area) Outside Inside Back

Is the pain: Sharp Dull (toothache) Constant Activity related

Does the pain wake you up at night?

Is the pain present: During activities After activities

What aggravates the symptoms?

Stairs	Crouching	Cutting, jumping sports
Long periods of sitting	Walking on level ground	Other:________________

How many city blocks could you walk before needing a rest?____

Have you had prior problems or surgery on this knee? Yes No

What makes the symptoms better?____

Have you had any treatment related to this injury? Yes No

If yes, please check off which treatments and any improvement:

Medications: Greatly helped Moderate help No help

Physical Therapy: Greatly helped Moderate help No help

Injections: Greatly helped Moderate help No help

Bracing or wraps: Greatly helped Moderate help No help

Other:____

With regards to this injury, have you had: X-Rays MRI Other

PAST MEDICAL HISTORY

Patient Name: ____ Date of Birth:_______________________

Height: _______ Weight: ________

Please list any conditions you are being treated for:____

____

Please list any medications you are currently taking____

____

Please list any surgical procedures:____

____

Medication Allergies:____ or No Known Drug Allergies

SOCIAL AND FAMILY HISTORY

Do you smoke: Yes No If yes, how many packs per day: ½ 1 2 More

Are you married? Yes No

Please list any conditions or diseases that run in the family:____

____

Review of Symptoms

Please check all that apply:

General:	Cardiovascular:	Musculoskeletal:	Neurological:
☐ Feeling Well	☐ Chest Pain	☐ Calf Pain	☐ Dizziness
☐ Fever	☐ Palpitations	☐ Joint Swelling	☐ Unsteadiness
☐ Chills	☐ Edema	☐ Joint Pain	☐ Weakness
☐ Fatigue	☐ Phlebitis	☐ Joint Stiffness	☐ Numbness
		☐ Muscle Weakness	☐ Unusual Sensation
Skin:	**Gastrointestinal:**	☐ Muscle Pain	☐ Fainting
☐ Bruising	☐ Heartburn/Reflux	☐ Muscle Atrophy	☐ Headaches
☐ Rash	☐ Constipation	☐ Leg Cramps	
Respiratory:	**Psychiatric:**	**Hematology:**	**Geniourinary:**
☐ Cough	☐ Anxiety	☐ Anemia	☐ Recurrent Urinary Infection
☐ Wheezing	☐ Depression	☐ Blood Clots	☐ Prostate Enlargement
☐ Difficulty Breathing	☐ Insomnia	☐ Nose Bleeds	☐ Prostate Cancer
	☐ Dementia		

Signature:____ Date______/______/______

Physician Signature:____Date______/______/______