



MEDICAL CENTER
ARTHRITIS • ORTHOPEDIC • SPORTS

KNEE INITIAL HISTORY FORM

NAME _____ DATE _____ AGE _____

Which knee hurts? Right Left Both

If both knees hurt, which one is worse? Right Left Equal

How long has your knee pain been present? Weeks Months Years

Did you suffer a specific injury to your knee? Yes No

If yes, please explain: _____

Where is your pain? Front Back Inside Outside

Do you walk: (/ one)

- With no assistance
- With a limp
- With a cane
- With crutches
- With a walker

Can you walk: (/ one)

- Unlimited
- Less than one block
- 1-5 blocks
- 5-10 blocks
- Unable to walk

Describe your activity level:

- Strenuous
- Moderate
- Light
- Mostly sedentary

Do you feel as if your knee is becoming "knock-kneed?" Yes No

Do you feel as if your knee is becoming "bow-legged?" Yes No

Does your knee feel weak and unstable? Yes No

Do you experience any catching, locking or popping in your knee? Yes No

Have you tried any anti-inflammatory medications for you knee? Yes No

Does your knee give out? Yes No

Do you have morning stiffness in your knee? Yes No

Any previous steroid (cortisone) injections: Yes No

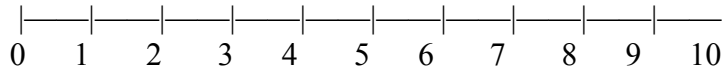
How many? _____

Did it help? Yes No

Circle the number on the line which best describes your knee in relation to the two extremes.

1. How often does your knee hurt?

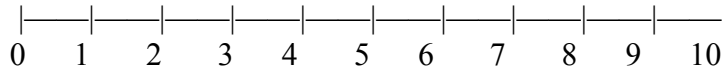
0 = Never



10 = Constant

2. If you have pain, how severe is it?

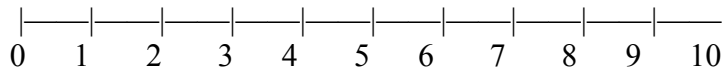
0 = Never



10 = Worst pain imaginable

3. Do you have pain while sitting?

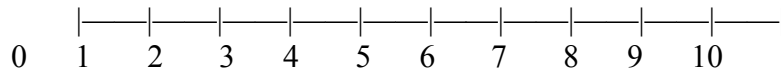
0 = Never



10 = Constant

4. Do you have difficulty going up or down stairs, or getting up from a chair?

0 = Never



10 = Constant

5. Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire or list any additional comments you wish to make regarding your condition.
