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PATIENT KNEE HISTORY FORM

Name: _____

Date of Birth: _____

Which Knee: ☐ **Left** ☐ **Right** ☐ **Both**

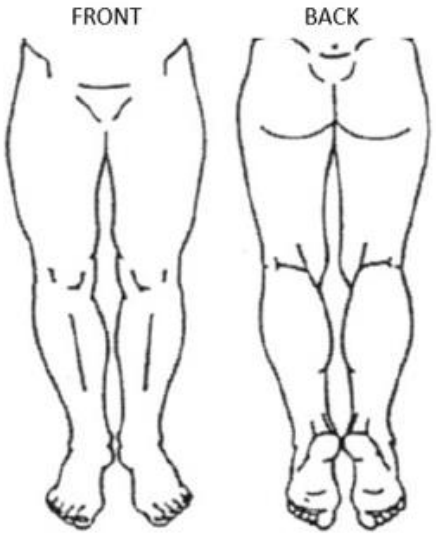
Chief Complain: _____

Problems with Your Knee: ☐ **Pain** ☐ **Stiffness** ☐ **Instability (Giving Way)** ☐ **Other** _____

When Did Your Problems Start: _____

How Did It Start (Ie. Fall/Injury/Sport/Work): _____

Where Do You Have Pain About the Knee?
(Please Indicate on Diagram)



Does Any Position / Activity Make the Pain Better / Worse: _____

Do You Have Knee Problems at Night: _____

Turning/Twisting in Bed: ☐ **Yes** ☐ **No** **Sitting to Standing:** ☐ **Yes** ☐ **No**

Do You Have Pain With Stairs: _____ **If So, Worse Up or Down:** _____

Swelling: ☐ **Yes** ☐ **No** **Giving Way:** ☐ **Yes** ☐ **No**

What Treatment(s) Have You Had So Far: _____

How Far/Long Can You Walk Before the Pain Stops You (Ie. 300m/30min):_____

Previous Problems or Surgery With Your Knee: _____

What Activities Do You Want To Return To: _____

Medical Conditions & Previous Surgeries: _____

_____

Do You Have a History of Blood Clots, Clotting Disorders or Bleeding Disorders: _____

Medications / Allergies: _____

_____