

Today's Date _____

Account # _____

PATIENT INFORMATION: Mr. _____
MRS. _____
MS. (LAST) (FIRST) (MIDDLE)
DOB _____

KNEE PATIENTS ONLY

Please indicate with a Yes or No to the following:

Did your knee swell up immediately? _____ After several hours? _____ The next day? _____

Does your knee swell up all the time? _____ Only after you have been active? _____

At night? _____ Other - Explain _____

Does your knee feel like it locks? _____ Gives away? _____ Slides in and out of joint? _____

Is your knee pain aggravated by climbing? _____ and/or descending stairs? _____

Sitting for long periods of time? _____ Kneeling? _____ Other - Explain _____

Is your knee pain on the inside? _____ Outside of knee? _____ Around the kneecap? _____

Under the kneecap? _____ At the back of the knee? _____ Other - Explain _____

Does aspirin relieve the pain? _____ Heat? _____ Ice? _____ Other medications? _____

What medication? _____ Rest? _____ Other - Explain _____

If it also helps reduce the swelling, please go back and circle the ones that reduce swelling.

What does it prevent you from doing?

Have you been treated for this or a similar problem in the past? _____

If yes, by whom and how was it treated? _____