ORTHOPEDIC ASSOCIATES
KNEE HISTORY

PATIENT:_____ DATE:_____

1. WHY ARE YOU BEING SEEN TODAY?_____
2. WHEN DID THE PAIN START AND WHAT WERE YOU DOING AT THE TIME OF INJURY OR ONSET OF PAIN? _____

   _____
3. DID YOU HEAR A POP IN YOUR KNEE WITH THE INJURY? ☐YES ☐NO
4. WHEN DID YOU NOTICE SWELLING? ☐IMMEDIATELY ☐WITHIN 1-2 HOURS ☐THAT NIGHT ☐THE NEXT DAY
5. WHERE IS THE PAIN LOCATED? ☐TOP OF KNEE ☐INSIDE ☐IN FRONT ☐OUTSIDE ☐ALL OVER ☐UNDER KNEE CAP
6. IS THE PAIN? ☐SHARP ☐STABBING ☐DULL ☐ACHING
   IS THE PAIN ☐CONSTANT ☐INTERMITTENT ☐OCCASIONAL ☐NONE AT ALL
7. WHEN DID THE PAIN START? ☐IMMEDIATELY ☐THE NEXT DAY ☐GRADUAL ONSET
8. WHAT HELPS DECREASE YOUR PAIN?_____
9. WHAT MAKES THE PAIN WORSE:_____
10. DO YOU HAVE: ☐POPPING ☐SNAPPING ☐GRINDING ☐CLICKING
    IN YOUR KNEE WITH BENDING OR STRAIGHTENING: ☐YES ☐NO ☐SOMETIMES
11. DO YOU HAVE DIFFICULTY WITH: GETTING IN AND OUT OF A CHAIR OR CAR? ☐YES ☐NO
12. DOES YOUR KNEE LOCK UP AND YOU ARE UNABLE TO BEND OR STRAIGHTEN IT? ☐YES ☐NO
13. DOES YOUR KNEE EVER BUCKLE OR GIVE OUT? YES NO SOMETIMES
14. CAN YOU SQUAT? ☐YES ☐NO CAN YOU KNEEL? ☐YES ☐NO
15. DO YOU FIND IT HARD TO GET GOING AFTER SITTING FOR MORE THAN AN HOUR? ☐YES ☐NO
16. WHAT TYPE OF RECREATIONAL SPORTS DID YOU DO (I.E. TENNIS, GOLD, SWIMMING, ETC.)?

    _____
17. PREVIOUS TREATMENT FOR THIS PROBLEM? _____
18. PRIOR INJURY? _____
19. MEDICATIONS?_____
20. PAST MEDICAL HISTORY?_____