OrthoTexas
Orthopedics & Sports Medicine

# KNEE



Patient Name *(print)*:_____

Was this an injury or did it occur over time?_____

How long have you had this problem or what was the date of your injury?_____

Where on your leg do you have the problem?_____

If an injury, describe how it occurred:_____

Have you had this problem before? Yes / No

If yes, how was it treated?_____

**Rate your pain:** No Pain 1 2 3 4 5 6 7 8 9 10 Absolute Pain

**Describe your pain (circle all that apply):**

| | | | |
|---|---|---|---|
| Sharp | Aching | Stabbing | Dull |
| Constant Burn | Come and go | Pins & needles | Electric |
| Explosive | Unrelenting | Throbbing | Other:_____ |
| Constant | Intermittent | Chronic | _____ |
| Getting better | Getting worse | Unchanged | |
| Worse in the morning | Worse in the evening | Worse at night | |

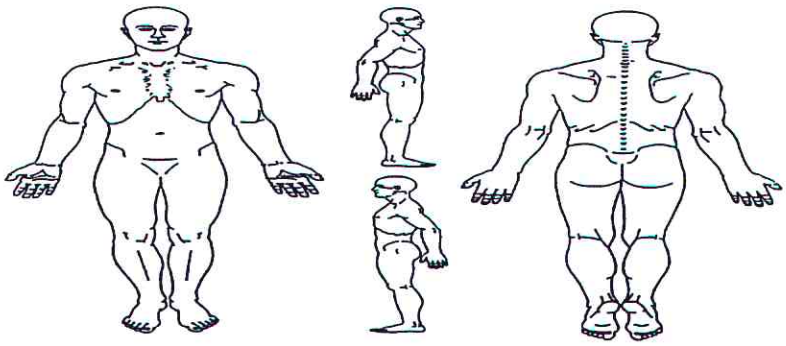
What makes your pain **worse**?_____

What makes your pain **better**?_____

Medications used for this problem:_____

Have you had any tests for this problem? MRI / Bone Scan / X-ray / Other_____

**Please indicate the location of your pain with an X:**



Do you have numbness or tingling? Yes / No If yes, where?_____

Do you have pain: Going Up Stairs / Going Down Stairs / Twisting?

Do you have swelling? Yes / No If yes, where?_____

Does your knee ever give way? Yes / No

Does your knee ever lock up? Yes / No

Do you have popping / catching / grinding?

Have you had a patella dislocation? Yes / No

Does your knee interfere with daily living? Yes / No

Has your knee interfered with your occupation? Yes / No

What type of sports do you usually do?_____

Are you participating in a sport now? Yes / No

Are there any other activities you wish to resume?_____

Do you have any other problems not previously described? Yes / No If yes, please describe:_____

_____

Referring Physician:_____

Other Physician(s) you have seen for this problem:_____

Have you had physical therapy for this problem? Yes / No

Date(s) of work/school missed for this problem:_____

Is there an attorney involved with this problem? Yes / No If yes, please provide additional information:_____

_____

Patient Name *(please print)*:_____

Patient Signature:_____ Date:_____