

Date: \_\_\_\_\_

# Knee History

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Knee (circle):            **Right**            **Left**            **Both**

Describe your problem or injury:

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Date of onset: \_\_\_\_\_

Describe prior problems or surgery on this knee:

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Describe treatment or medicines used for this problem:

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Describe other bone or joint problems:

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Check all complaints present:

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|-------|---------------------------------|-----------------------------|------------|-------------|
| _____ | Swelling                        |                             |            |             |
| _____ | Pain                            | Circle one: Mild            | Moderate   | Severe      |
|       |                                 | Circle location: Inner knee | Outer knee | Entire knee |
| _____ | Popping noise or grinding       |                             |            |             |
| _____ | Catching or locking             |                             |            |             |
| _____ | Giving way or buckling          |                             |            |             |
| _____ | Limping                         |                             |            |             |
| _____ | Use of cane or crutches         |                             |            |             |
| _____ | Pain with standing or walking   |                             |            |             |
| _____ | Night pain                      |                             |            |             |
| _____ | Morning pain or stiffness       |                             |            |             |
| _____ | Pain with squatting or kneeling |                             |            |             |