

Knee Pain Questionnaire

Name _____

Which knee is bothering you? Right Left Both

Did your knee pain start with a specific injury? Yes No

If yes: Date of injury: _____

Mechanism of injury _____

Did you feel a pop or snap with the injury? Yes No

Is the injury work related? Yes No

Did your pain start with a particular sport or activity? Yes No

If yes, what started the pain? _____

If there was no injury, when did the pain start? _____

What part of your knee hurts? Front Inside Outside Back

What are your primary sports and/or activities? _____

How would you describe your pain? (constant, intermittent, mild, severe, etc.)

Do any of the following increase your pain?

Prolonged walking: Yes Minimally No

Prolonged standing: Yes Minimally No

Going up or down stairs: Yes Minimally No

Prolonged sitting: Yes Minimally No

Getting up from a sitting position: Yes Minimally No

Kneeling or squatting: Yes Minimally No

Pivoting or twisting motions: Yes Minimally No

Running: Yes Minimally No

Sports: Yes Minimally No

Is there anything else that increases your pain? _____

Do any of the following decrease your pain?

Rest: Yes Minimally No

Ice: Yes Minimally No

Heat: Yes Minimally No

Over the counter medicines (Tylenol/Advil) Yes Minimally No

Prescription pain medicines: Yes Minimally No

Is there anything else that decreases your pain? _____

Do you have any of the following symptoms?

| | | | |
|--|-----|-----------|----|
| Weakness in your leg: | Yes | Minimally | No |
| Giving way or buckling of your knee: | Yes | Minimally | No |
| Locking of your knee (unable to fully straighten): | Yes | Minimally | No |
| Clicking or catching in your knee: | Yes | Minimally | No |
| Grinding sensation in your knee: | Yes | Minimally | No |
| Swelling of your knee: | Yes | Minimally | No |
| Stiffness: | Yes | Minimally | No |
| Pain at night: | Yes | Minimally | No |
| Numbness or tingling in your leg: | Yes | Minimally | No |

Are there any other symptoms that we need to know about regarding your knee?

Have you had any prior surgery to your knee(s)? Yes No
If yes, what type of surgery did you have and when did you have the surgery?

Have you had any prior treatment for your knee pain such as:

| | | |
|--|-----|----|
| Cortisone injections: | Yes | No |
| Synvisc, Euflexxa or "Gel" injections: | Yes | No |
| Physical therapy: | Yes | No |

Do you use any ambulatory aids (cane, crutches, walker) Yes No

Have you had any x-rays taken of your knee(s): Yes No

If yes: Date of x-rays: _____
 X-ray facility: _____

Have you had an MRI of your knee(s): Yes No

If yes: Date of MRI: _____
 MRI facility: _____

Is there anything else we need to know about your knee pain?

Thank you for filling out this form