

# ***KNEE QUESTIONNAIRE***

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Date \_\_\_\_\_  
Occupation \_\_\_\_\_

1. Medical Conditions: (check all that apply, past or current)

- None known  
 Respiratory  Asthma  Emphysema  Other \_\_\_\_\_  
 Heart  Coronary Artery Disease  Heart attack/s  Valve Problems  
 Other \_\_\_\_\_  
 High Blood Pressure  
 Stroke  
 Stomach / GI  Reflux  Ulcer  
 Kidney Disease  
 Diabetes:  Insulin  Oral Medication  Diet  
 Rheumatoid Arthritis  Raynaud's  Lupus  Multiple Sclerosis  
 Fibromyalgia  Gout  
 Endocrine Disorder  Thyroid ( Hypo  Hyper)  
 Lyme Disease  
 Blood Disorder  Bleeding Problem  Anemia  
 Hepatitis  A  B  C  
 Cancer \_\_\_\_\_  
 Tumor/s  Benign  Malignant  
 Osteopenia / Osteoporosis  
 Reflex Sympathetic Dystrophy (RSD) or **Complex Regional Pain Syndrome**  
 Neuropathy  Neuritis  
 Treatment for Pain Management  
 Depression  Alcoholism  Drug Dependency  
 Other \_\_\_\_\_

2. Surgical History :

<u>Type of operation</u>	<u>Date</u>	<u>Hospital</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Current medications & dosage: (including over-the-counter, herbal, etc.)

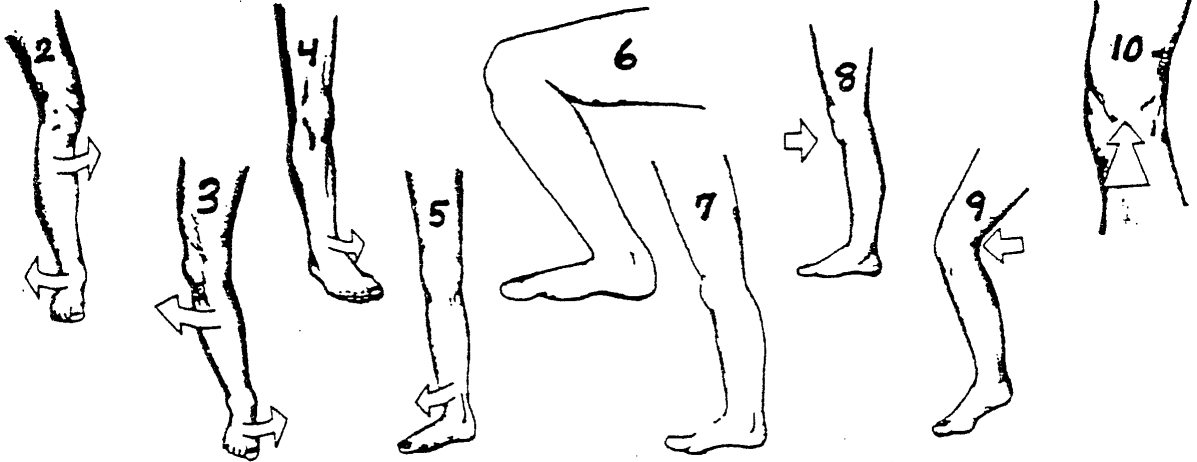
_____	_____
_____	_____
_____	_____
_____	_____

4. Allergies: (medication, food, latex, etc.)

\_\_\_\_\_  
\_\_\_\_\_

(OVER)

5. Is this problem related to \_\_\_ sports, \_\_\_ work, \_\_\_ auto, \_\_\_ other \_\_\_\_\_
6. Which knee bothers you? Right\_\_\_ Left\_\_\_ Both\_\_\_
7. During what sport or activity did the injury/problem occur? \_\_\_\_\_
8. When did the injury or problem first appear?  
Month \_\_\_ Day \_\_\_ Year \_\_\_
9. Was there a “pop” during the injury? Yes\_\_\_ No\_\_\_
10. Did your knee shift out of joint during the injury? Yes\_\_\_ No\_\_\_
11. How long after the injury did you experience swelling?  
Never\_\_\_ Within 4 hrs. \_\_\_ Within 12 hrs. \_\_\_ Within 24 hrs. \_\_\_
12. Does your knee ever lock? Yes\_\_\_ No\_\_\_
13. Do you have pain with: (check all that apply)  
Stairs\_\_\_ Kneeling/Squatting\_\_\_ Sitting\_\_\_ Other \_\_\_\_\_  
Running\_\_\_ Walking\_\_\_ Standing\_\_\_ Sleeping\_\_\_
14. Which picture best describes your injury?



- |                                   |                                 |
|-----------------------------------|---------------------------------|
| 1. Never had an injury            | 7. Knee straightened            |
| 2. Knee went in and foot went out | 8. Leg and knee hit in front    |
| 3. Knee went out and foot went in | 9. Leg and knee hit from behind |
| 4. Foot twisted in                | 10. Kneecap struck              |
| 5. Foot twisted out               | 11. Unsure of injury mechanism  |
| 6. Knee bent                      |                                 |

15. What knee problems are you currently experiencing?
- |                         |                          |
|-------------------------|--------------------------|
| ___ Pain                | ___ Giving way           |
| ___ Swelling            | ___ Crepitus or cracking |
| ___ Locking or catching |                          |

16. Who first saw and evaluated your injury? When? \_\_\_\_\_  
 \_\_\_\_\_ Emergency room physician  
 \_\_\_\_\_ Family physician \_\_\_\_\_ Orthopedic Surgeon  
 \_\_\_\_\_ Coach or trainer \_\_\_\_\_ Other \_\_\_\_\_

17. What was the first diagnosis after your injury or problem?  
 \_\_\_\_\_

18. What other treatments, if any, have you received for this problem?  
 (i.e. brace, physical therapy, etc.) \_\_\_\_\_  
 \_\_\_\_\_

19. If you have had any other knee problems in the past, please identify them:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

20. What is the nature of your pain? ( dull, sharp, burning, throbbing, aching)  
 \_\_\_\_\_

21. Do you notice that your knee has any temperature changes? (hot, cold) \_\_\_\_\_  
 \_\_\_\_\_

22. Do you notice any skin color changes? If yes where? \_\_\_\_\_  
 \_\_\_\_\_

23. Is light touch to skin painful? \_\_\_\_\_  
 \_\_\_\_\_

24. Does ice application cause increased pain? (yes, no) \_\_\_\_\_  
 \_\_\_\_\_

25. Please check the appropriate level of pain, swelling and giving way in both knees (if level is changed by the use of a brace please indicate this level with a "B").

<b><u>Pain:</u></b>	<b><u>Right</u></b>	<b><u>Left</u></b>
1. Severe with daily activities	_____	_____
2. Moderate with daily activities	_____	_____
3. Slight with daily activities	_____	_____
4. With light recreational sports	_____	_____
5. With hard jumping, twisting or competitive sports	_____	_____
6. No pain with any activity	_____	_____

(OVER)

Please check the appropriate level of pain, swelling and giving way in both knees (if level is changed by the use of a brace please indicate this level with a “B”).

**Swelling:**

**Right**

**Left**

- |  |       |       |
|--|-------|-------|
| 1. Severe with daily activities                      | _____ | _____ |
| 2. Moderate with daily activities                    | _____ | _____ |
| 3. Slight with daily activities                      | _____ | _____ |
| 4. With light recreational sports                    | _____ | _____ |
| 5. With hard jumping, twisting or competitive sports | _____ | _____ |
| 6. No swelling                                       | _____ | _____ |

**Giving way:**

**Right**

**Left**

- |  |       |       |
|--|-------|-------|
| 1. Severe with daily activities                      | _____ | _____ |
| 2. Moderate with daily activities                    | _____ | _____ |
| 3. Slight with daily activities                      | _____ | _____ |
| 4. With light recreational sports                    | _____ | _____ |
| 5. With hard jumping, twisting or competitive sports | _____ | _____ |
| 6. No giving way                                     | _____ | _____ |