ORTHOPEDIC KNEE QUESTIONNAIRE

PATIENT NAME: _____ **TODAY'S DATE:** _____

CHIEF COMPLAINT: _____ (Why are you seeing the doctor today?)

AFFECTED SIDE: ☐ Right Knee ☐ Left Knee ☐ Both Knees

REFERRED BY: _____
(Physician) (City, State)

ONSET OF CONDITION: ☐ Sudden ☐ Gradual

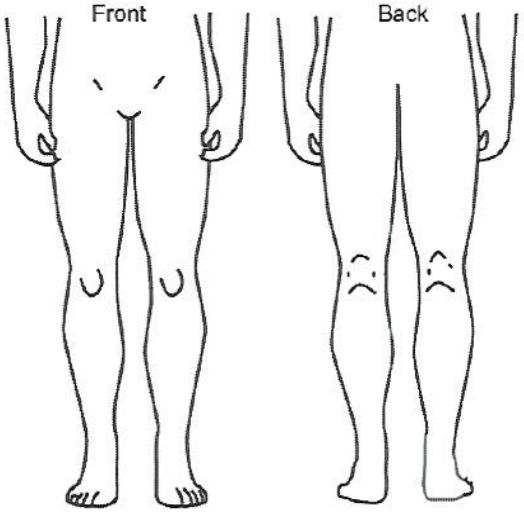
PRIOR PROBLEMS? ☐ No ☐ Yes
CURRENTLY ABLE TO WORK? ☐ No ☐ Yes

TREATMENTS TRIED	HELPED (Makes pain better)	NO EFFECT OR WORSENED (Makes pain worse or same)	NOT HAD (Not tried or needed)
Rest	☐	☐	☐
Heat or Ice	☐	☐	☐
Cane, crutches, walker	☐	☐	☐
Physical Therapy	☐	☐	☐
Tylenol	☐	☐	☐
Anti-inflammatory medication (Advil, Aleve, Ibuprofen)	☐	☐	☐
Narcotic Medication	☐	☐	☐
Stretching or Strengthening	☐	☐	☐
Glucosamine/Chandroltin	☐	☐	☐
Hyalgan/Symvisc	☐	☐	☐
Cortisone/Steriod injections	☐	☐	☐
Surgery	☐	☐	☐

CURRENT SYMPTOMS:

Do you have any swelling?	☐ No	☐ Yes
Do you limp?	☐ No	☐ Yes
Do you have locking, grinding or catching with your pain?	☐ No	☐ Yes
Does your knee feel unstable or does it give way?	☐ No	☐ Yes
Do you have morning stiffness?	☐ No	☐ Yes
Do you have hip or groin pain?	☐ No	☐ Yes
Does your knee bother you at rest or at night, wake you up?	☐ No	☐ Yes
Have you had to quit activities?	☐ No	☐ Yes

Place an "x" where you have the most pain.
Shade the areas where you have lesser pain.



Signature of Patient or Legally Responsible Party Date (month/day/year)

Relationship to patient, if not signed by patient

PATIENT NAME & ID #

VIRGINIA MASON MEDICAL CENTER – Seattle WA

Orthopedic Knee Questionnaire

CNHISTORY