Patient Name:_____

GSMG Orthopaedic Surgery

Date of Birth_____ /_____ /_____

Knee History

Date of Visit: ____ /____ /_____

Which knee are we seeing you for? (circle ONLY ONE of the following): *Right/ Left/ Both*

What bothers you the most about your knee(s)? (circle ONLY ONE of the following):
Pain, Swelling, Catching, Locking, Instability(Giving Out), Deformity(crookedness), Grinding, Popping
*Other:*_____

What else bothers you about your knee(s)? (circle ALL of the following that apply to your knee(s):
Pain, Swelling, Catching, Locking, Instability(Giving Out), Deformity(crookedness), Grinding, Popping
*Other:*_____

When did the knee symptoms begin? _____

Are symptoms worsening/progressing over time? Yes/No

Was there ever an injury to the knee? Yes/No If "Yes", when was the injury? _____
If "Yes", how was it injured? _____

Have you ever had surgery performed on your RIGHT knee? Yes/No

If "Yes", what type of surgery(s) and when? (1)_____ (3)_____
(2)_____ (4)_____

Have you ever had surgery performed on your LEFT knee? Yes/No

If "Yes", what type of surgery(s) and when? (1)_____ (3)_____
(2)_____ (4)_____

Have you ever had an infection in either knee? Yes/No _____

Have you ever had a blood clot (DVT) in either leg? Yes/No _____

Have you ever had a blood clot go to your lungs (pulmonary embolism)? Yes/No _____

Does your RIGHT HIP bother you? Yes/No _____

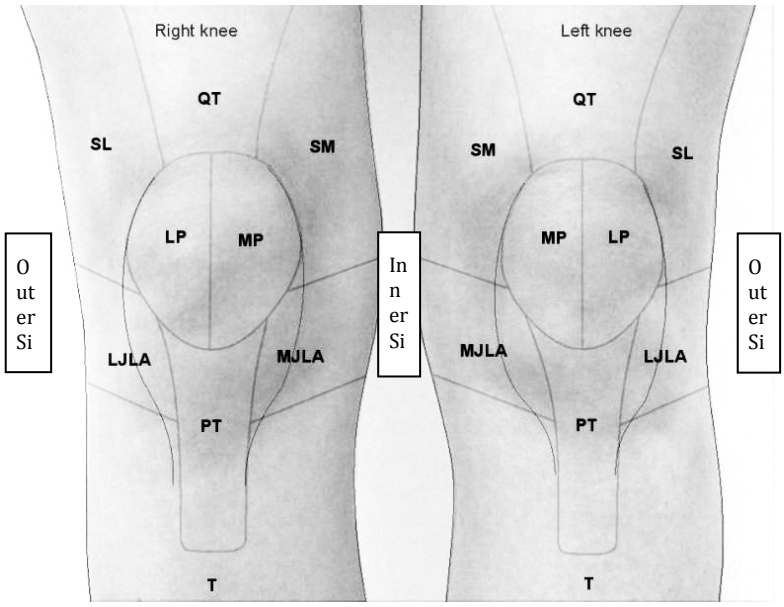
Does your LEFT HIP bother you? Yes/No _____

Does your LOW BACK bother you? Yes/No _____

Do you ever have numbness or tingling in either leg or foot? Yes/No _____

Where is your KNEE pain located?*(please mark location on the diagrams below with X's or arrows)*

Right Knee: Left Knee:



Right Knee:
In Front
In Back
Inner Side
Outer Side
Behind the knee cap
Below the knee cap
Above the knee cap

Left Knee:
In Front
In Back
Inner Side
Outer Side
Behind the knee cap
Below the knee cap
Above the knee cap

Is your knee pain aggravated by activity that involves bearing weight (walking / standing)? Yes/No

Is your knee pain alleviated by rest (avoiding activity)? Yes/No

Do you have pain in your knee at night? Yes/No
If "Yes", does your night pain interfere with sleep? Yes/No

What activities aggravate your knee? _____

_____

What activities have you had to limit or avoid because of your knee? _____

_____

Do you feel that your quality of life is suffering because of your knee ? Yes/No _____
If "Yes", how much is your quality of life suffering?
(Please circle one of the following): *Mildly / Moderately / Severely*

Is your quality of life suffering enough for you to consider knee surgery? Yes/No _____

Prior Treatment

Have you used medication(s) for your knee? Yes/No

Medication Name:	Did it Help?	Are you still taking it?
(1) _____:	Yes/No _____:	Yes/No
(2) _____:	Yes/No _____:	Yes/No
(3) _____:	Yes/No _____:	Yes/No
(4) _____:	Yes/No _____:	Yes/No
(5) _____:	Yes/No _____:	Yes/No

Has your knee ever been injected with cortisone? Yes/No
How many times? _____ Did cortisone injection(s) help? Yes/No

Has your knee ever been injected with Synvisc/Hyalgan/Orthovisc/"Rooster Comb"? Yes/No
How many times? _____ Did these injection(s) help? Yes/No

Have you used a brace for your knee? Yes/No Did this help? Yes/No

Have you had physical therapy for your knee? Yes/No Did this help? Yes/No

Have you had chiropractic treatment for your knee? Yes/No Did this help? Yes/No

Do you use a cane/walking stick because your knee? Never/Sometimes/Always/ In the past

Do you use a walker because your knee? Never / Sometimes / Always/ In the past

Do you use crutches because your knee? Never / Sometimes / Always/ In the past

What other treatment(s) have you tried? _____ Did this help? Yes/No
_____ Did this help? Yes/No
_____ Did this help? Yes/No

Is there any other information that you would like to share with us about your knee?
_____
_____
_____
_____
_____

Thank you very much for completing all of this form!