KNEE QUESTIONNAIRE

Patient Name : _____
Last name, First name

What knee is painful - Right or Left (Please circle)

1) How long have you had knee pain? Days ____ Weeks ____ Months____ Years _____

2) Were you injured? Yes_____ No _____ - If yes, how did it happen? Describe briefly.
_____
_____

3) Does your knee hurt with;

   a) Walking? Yes _____ No _____

   b) Stair climbing? Yes _____ No _____

   c) Bending? Yes _____ No _____

   d) Rising from a sitting position? Yes _____ No _____

4) Does your knee – Swell? Yes_____ No _____

   Lock? Yes _____ No ____

   Give out on you? Yes____ No _____

5) Have you ever received previous treatment or have you undergone surgery on your knee?
Explain Briefly:_____
_____

6) Have you had any x-rays performed? Yes _____ No _____,

   An MRI of the knee? Yes _____ No _____ If yes, where and when_____
   _____