SPORTS MEDICINE, ARTHRITIS,
& JOINT REPLACEMENT

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KNEE QUESTIONNAIRE

DATE OF VISIT:____________________ PATIENT NAME:____

At baseline, what did/do you do for exercise and how often did/do you do each activity: __________________
____

Which knee is bothering you? ☐ RIGHT ☐ LEFT ☐ BOTH (which is worse: _______________)
When did the pain begin? ____________________
Cause of pain: ☐ Gradual onset ☐ Sports injury ☐ Accident ☐ Work comp injury
If there an injury occurred, describe what happened and when?

Any prior significant issues with that knee: ☐ No ☐ Yes

- Describe any previous injuries____
- List any previous injections (when and with whom): ____
- List any previous surgeries (when, what, and surgeon's name): ________________________________

Frequency of pain: ☐ Constant ☐ Intermittent
Pain level at rest, i.e. when not moving (please circle): 0 1 2 3 4 5 6 7 8 9 10 (10 is max)
Highest level of pain (please circle): 0 1 2 3 4 5 6 7 8 9 10 (10 is max)

Do you have buttock pain?: ☐ No ☐ Yes (describe when/what):
Do you have pain radiating down your leg?: ☐ No ☐ Yes: right / left / both (please circle)
Have you had back surgery or injections?: ☐ No ☐ Yes (describe when/what):
Have you have groin pain?: ☐ No ☐ Yes
Have you had a hip replacement?: ☐ No ☐ Yes (please circle: Right Left)

Describe the pain: ☐ Aching ☐ Sharp ☐ Constant aching with sharp pain on movement
Do you experience : ☐ Grinding ☐ Catching (gets stuck for a moment) ☐ Locking (gets stuck and you have to manipulate it to unlock it) ☐ Buckling (gives out on you) ☐ Clicking ☐ Popping ☐ Snapping ☐ Feeling of instability ☐ Swelling
What causes pain: ☐ Sitting for long periods of time ☐ Going from sitting to standing ☐ Stairs ☐ Uphill/downhill walking ☐ Twisting ☐ Kneeling ☐ Squatting ☐ Getting in/out of car

When is pain the worst? ☐ Morning ☐ At the end of the day ☐ Trying to get to sleep
Is it hard to fall sleep? ☐ No ☐ Yes
Does pain wake you from sleep? ☐ No ☐ Yes

Have you tried any of the following to relieve pain? ☐ Rest ☐ Heat ☐ Cold ☐ Home exercises ☐ Massage ☐ Acupuncture
If you have had Physical Therapy: What facility: ____________________; How many sessions: ____________
When was the last session: ______________________
List any medications taken for knee pain (name, dosage, and frequency): ______

Are you getting: ☐ Better ☐ Worse ☐ No change