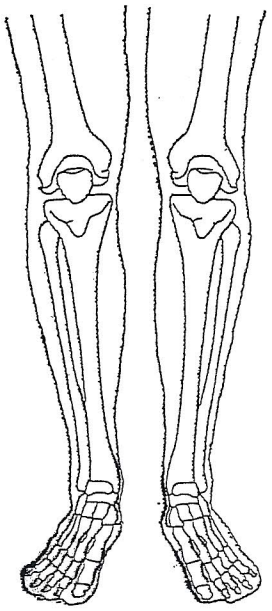
Patient # _____

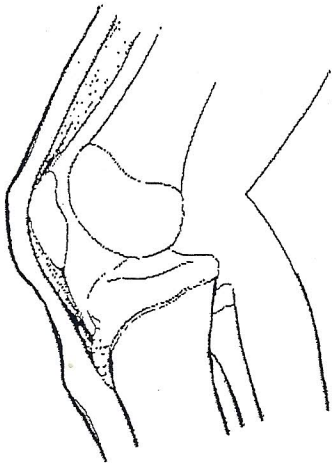
Date _____

Knee



RIGHT

LEFT



Please circle on the above drawing where you are having pain or symptoms.

Describe the sensations or symptoms you are experiencing (pain, aching, tingling, burning, numbness, etc.)

_____

Is this a result of an injury? **YES** ____ **NO** ____ If YES, give the date? _____(month-day-year)

If YES, explain how and where your injury occurred:_____

_____

Is this work related? **YES** ____ **NO** ____

If this was not an injury, how long have you been experiencing your symptoms? _____

Which knee will we be examining? **Left** ____**Right** ____

Have you had surgery on this knee? **YES** ____ **NO** ____ If YES, when and where did you have surgery?

_____

Did the surgery help? **YES** ____ **NO** ____

Have your symptoms reoccurred or come back? **YES** ____ **NO** ____ **Suddenly** ___ or **Gradually** ___

Are the symptoms now in a different area? **YES** ____ **NO** ____ If YES, explain _____

_____

Is your knee unstable (does your knee collapse when you are walking)? **YES** ____ **NO** ____

Does your knee lock? **YES** ____ **NO** ____ Does it click **YES** ____ **NO** ____

Have you ever had x-rays, a CT scan, or MRI scan for *this* problem? **YES** ____ **NO** ____ If YES, when and where, and what did they show? _____

Have you ever been diagnosed with cancer? **YES** ____ **NO** ____ If YES, when? _____

If YES, to what part of the body? _____

If YES, what kind of treatment was given? _____

If YES, what was the last date of your treatment? _____

Please give us your **HEIGHT** _____ **WEIGHT** _____