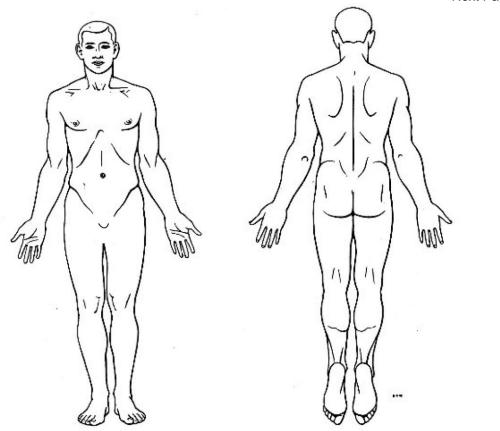
Beaumont

Knee Questionnaire

| Name: | | Age: | Weigh | t: |
|---|----------------------------|-----------------------|-------------------|---------------|
| Which knee(s) bothers you? Right | Left | | | |
| How long has this been going on? | | | | |
| Do you know what caused the problem? If yes, | describe: | | | |
| Did you ever injure the knee? If yes, when: | | | | |
| Have you ever had surgery or arthroscopy on yo | our knee? | Right L | eft | |
| If yes, when and where? | | | | |
| Have you had any x-rays, CAT scan (CT) | , Ultras | ound, MRI | of your k Righ | |
| f yes, when and where? | | | | |
| oid you submit any of the above exams for comparison? ino, can you submit these for comparison to today's exam? | | | ′es ′es | No No |
| If you have knee pain, describe it: (check all that apply) Dull Aching Sharp | Does your keepop or click? | | | es No |
| Constant Intermittent Pain with walking up or down stairs Yes No Pain with bending knee Yes No Pain with jumping Yes No | If yes how of | : Day Week | Month | es No Year |
| Pain with other activity (describe) | | Only after exercis | se | |
| Location of pain: Front Back Inner aspect Duter aspect | | dislocate your patell | Yes No | |
| How bad is the pain? (on a scale from 1 to 10, where 1 = minimal pain, 10 = terrible pain) | | | | |
| Do you exercise or play sports? If yes, describe | : | | | |
| Do you take any medications for your knee prob | lem? If yes list | : | | |
| Do you have history of any cancer? If yes descr | ibe: | | | |
| Please add anything else that you think might be | e important: | | | |
| List any other medications, medical problems or | surgeries | | | |
| Medicine allergies Latex allergies | | | | |



Using the figures, please shade in the areas affected by pain and/or numbness. Please be precise.