Knee Evaluation

Please be as complete as possible and print clearly

Name:____ Today's Date___/___/___ Age:_____ Height:________ Weight:__________

Occupation:____ Family Physician:____

Who referred you to this office?____

Involved Knee: ☐ Right ☐ Left ☐ Bilateral

HISTORY OF INJURY

Did you have an injury to your knee? ☐ Yes ☐ No

When did the injury occur or when did *the symptoms* begin (day, month, year)?____

How did the injury occur?____

____

Do you have ☐ Pain ☐ Loss of motion ☐ Swelling ☐ Burning or numbness

☐ Mechanical Symptoms (feels like there's a pebble in your knee)

☐ Instability of buckling

Location of your knee pain: ☐ Front of knee (kneecap area) ☐ Outside ☐ Inside ☐ Back

Is the pain: ☐ Sharp ☐ Dull (toothache) ☐ Constant ☐ Activity related

Does the pain wake you up at night?

Is the pain present: ☐ During activities ☐ After activities

What aggravates the symptoms?

☐ Stairs ☐ Crouching ☐ Cutting, jumping sports

☐ Long periods of sitting ☐ Walking on level ground ☐ Other:________________

How many city blocks could you walk before needing a rest?____

Have you had prior problems or surgery on <u>this knee</u>? ☐ Yes ☐ No

What makes the symptoms better?____

Have you had any treatment related to this injury? ☐ Yes ☐ No

If yes, please check off which treatments and any improvement:

☐ Medications: ☐ Greatly helped ☐ Moderate help ☐ No help

☐ Physical Therapy: ☐ Greatly helped ☐ Moderate help ☐ No help

☐ Injections: ☐ Greatly helped ☐ Moderate help ☐ No help

☐ Bracing or wraps: ☐ Greatly helped ☐ Moderate help ☐ No help

Other:____

With regards to this injury, have you had: ☐ X-Rays ☐ MRI ☐ Other

PAST MEDICAL HISTORY

Please list any conditions you are being treated for:____

____

Please list any medications you are currently taking:____

____

Please list any surgical procedures:____

____

Medication Allergies:____ or ☐ No Known Drug Allergies

SOCIAL AND FAMILY HISTORY

Do you smoke: ☐ Yes ☐ No If yes, how many packs per day: ☐ ½ ☐ 1 ☐ 2 ☐ More

Are you married? ☐ Yes ☐ No

Please list any conditions or diseases that run in the family:____

____

REVIEW OF SYSTEMS

Please check off if you have any of the problems listed below:

Migraines	☐ Yes	☐ No	Bleeding disorders	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	Phlebitis/blood clots	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Psoriasis or gout	☐ Yes	☐ No
Ulcer/stomach probs	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No

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Exam Findings

Gait analgic	Yes No	Pivot shift +	Yes No
Full AROM	Yes No	Post draw	- +
Full PROM	Yes No	Med jt line pn	Yes No
Effusion	Yes No	Lat jt line pn	Yes No
Crepitus	Yes No	McMurrays	- +
Patellar Grind	Yes No	Pat ten pan	Yes No
Pat apprehsn	Yes No	DP Pulse	2+ 1+ 0
Var/valg stab	Yes No	PT Pulse	2+ 1+ 0
Lachman stab	- +	Skin abrasion	Yes No

Other tests:

Physician signature:________________________________ Date:____________________________