beach cities orthopedics & sports medicine

KNEE EVALUATION

Today's date: _____

Name: _____ **Age:** _____ **Sex:** _____ **Chart:** _____

Knee (circle one): L / R How long have you had symptoms? _____

My major complaint is (circle all that apply)

Pain Dull ache Loss of motion Swelling Grinding Giving out Locking

Did this problem start…(Please circle one):

Gradually Vehicle accident While at work Suddenly While playing sports- which sport? _____

The primary location of pain is (circle all that apply):

Kneecap Throughout the knee Outer side Behind knee Inner side Deep inside

When does the affected knee hurt? (Please circle one):

Infrequently Constantly When active

Does the pain in the affected knee occur at night? (Circle one) Yes No

If yes, does it awaken you? (Circle one) Yes No

When is the pain made worse? (Circle all that apply):

Sitting Standing Walking Climbing stairs Getting up Running During physical exercise

The pain is relieved by: (Circle all that apply):

Nothing Rest Cold therapy Pulls Heat therapy Activity Moving the knee

Is the affected knee ever swollen? (Circle all that apply):

Never Only after exercise Infrequently Constantly At the time of the original injury, but not since

Are there any grating or grinding noises or sensations in the joint? (Circle all that apply):

None When climbing stairs When getting up from a chair When descending stairs

When walking When doing deep knee bends

What is the range of motion in the affected knee? (Circle one)

Same as ever Unable to fully straighten the joint Unable to fully bend or flex the joint

Mobility of the joint: Are you able to walk normally? (Circle one) Yes No

Do you walk with a limp? (Circle one) Yes No

What activities are you <u>UNABLE</u> to do? (Circle one)

Walk Climb Jump Squat Run None of the above