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Name _____ Chart # _____ Today's Date _____

Which knee? L R If injured, date of injury: _____ Occupation: _____

Is this injury due to an accident? Yes No On the job? Yes No Motor Vehicle? Yes No

Are you currently out of work or on limited duty due to this injury? Yes No How long? _____

If not injured, date of onset of symptoms: _____ Duration of symptoms: _____

How far could you walk prior to pain? _____

Do you avoid physical activity such as long distances, shopping, going up stairs? Yes No

Do you have a regular exercise program? Yes No

What is your amount of pain at rest? Least = 1 1 2 3 4 5 6 7 8 9 10 Most = 10

Do you have pain during or immediately after activity? Least = 1 1 2 3 4 5 6 7 8 9 10 Most = 10

Do you consider your pain: Annoying Inconvenient Restricting Disabling

Past history of knee problems? _____

Any prior knee surgeries? Yes No Which knee? L R Procedure: _____

When? _____ Where? _____ Doctor: _____

Have you seen another doctor for this injury? Yes No Doctor: _____

Is this appointment for a second opinion? Yes No

Please write a brief description of how your injury or symptoms happened: _____

Please indicate in the boxes that apply with a ✓

Do you have?	Which knee?		Frequency		
	L	R	With activity	Weekly	Rarely
Locking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Giving way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Popping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grinding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty w/stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uneven terrain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What previous treatments have you tried?

Chondroitin/glucosamine or other cartilage supplements _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical therapy _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Steroid injections _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hyaluronic Injections (Hyalgan, Supartz, Synvisc, Etc) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other medications (Celebrex, Aleve, Tylenol, etc. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ice _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bracing _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shoe inserts _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Activity modification _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cane or walking stick _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patient Signature: _____ Date _____