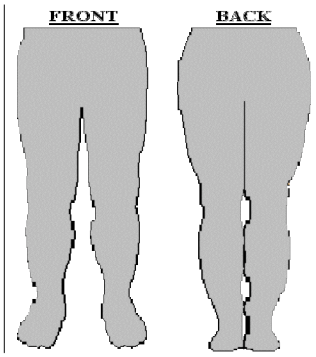
Fletcher Allen **Name**:
Adult Reconstruction Service **DOB:**
KNEE PAIN HISTORY Age: _____ **Sex: M F**
(Please complete both pages of this form)

Weight: _____ lbs Height: _____ BMI: _____ Recent weight loss or gain? Yes ___ No _

Which knee is bothering you? Right ___ Left ___ Both ___
How long has it bothered you? Right ____ Days ____ Months ____ Years ____
Left ____ Days ____ Months ____ Years ____

Occupation: _____ Length of time at this job? Years: ____ Months: ____ Days:___
Previous Job History: _____ Years _____



DID YOU HAVE A SPECIFIC INJURY? Yes ____ No ____
If yes, date of injury: __/__/____ Where? _____
Describe how it happened? _____
If no, describe onset: Sudden ____ Gradual ____ At Night ___

DESCRIBE YOUR KNEE PROBLEM/COMPLAINT (circle all that apply)
__ **Pain Where?** Front Back Inside Outside
Other: _____
Severity? Occasional Mild Moderate Severe
At Rest Awakes you at night?
Does the pain go down your leg? Yes No **Below the ankle?** Yes No
What activities hurt your knee(s)?
stairs squatting sitting putting on shoes/socks driving intimacy
Do you walk with a limp? Yes No
Do you walk with a: Cane Walker Crutches
How far can you walk? Unlimited _ mile 100 yards indoors only
Other knee symptoms? swelling redness morning stiffness weather-related pain
__ **Other joint complaints (describe)** _____

PRESENT ACTIVITY LEVEL: (Check highest level manageable)
__ Total incapacity
__ Able to do activities of daily living, but unable to participate in activities outside home
__ Able to participate in social activities outside the home, some activities are limited by pain
__ Able to do regular social and recreational activities with occasional pain
__ Able to do all social and recreational activities, including sports without pain

HAVE YOU HAD THIS PROBLEM/SIMILAR COMPLAINT BEFORE? (circle) **Yes No**

If yes, who treated you?_____ Which office? _____
When? __/__/____ to __/__/____ Did you have any relief? _____
What were you told your problem was? _____
_____

HAVE ANY X-RAYS BEEN TAKEN FOR YOUR KNEE(S) ? (circle) **Yes No**

If yes, where were the x-rays taken? _____

When were the x-rays done? _____

OTHER TESTS:

	Where	**When**
Bone Scan	_____	_____
CT Scan	_____	_____
MRI Scan	_____	_____
Arthrogram (dye test)	_____	_____
Aspiration(fluid removed)	_____	_____
Biopsy (tissue removed)	_____	_____
Blood Test(s)	_____	_____

DESCRIBE ANY TREATMENT YOU HAVE HAD FOR THIS PROBLEM:

____ Medication(s) Name: _____ dose: _____

_____ _____

____ Physical Therapy Where: _____ When: _____to _____

____ Injection(s) Where were you injected: outside of knee? inside knee joint? (circle)

How many injections: 1 2 3 more than 3 (circle)

____ Surgery Surgeon: _____ When: _____ Where: _____

What was found? _____

_____

MARK YOUR TYPICAL DAILY PAIN LEVEL ON THIS LINE:

"L" for lowest "P" for present "H" for highest

1 ----------5----------10

No pain Worst possible pain

CURRENT SPORTS PARTICIPATION: (circle) Walking Hiking Running Cycling Swimming Canoe/Kayak Skiing Baseball/Softball Basketball Soccer Rugby Tennis Other: _____

What are your goals for today's visit? (please write out any questions you have for your Doctor)

_____

_____

_____

_____

Patient signature _____ Staff signature _____ Date __/__/____