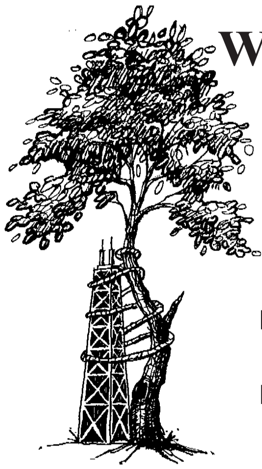


WINDY CITY ORTHOPEDICS & SPORTS MEDICINE

2617 W. Peterson Avenue Chicago, Illinois 60659
Toll Free 877-549-4490 Suburban 847-475-0200 Chicago 773-743-1981

TODAY'S DATE ______/______/______

PATIENT INFORMATION QUESTIONNAIRE: KNEE

NAME____
FIRST MIDDLE LAST

HEIGHT ____________ WEIGHT _____________ AGE ___________

I AM RIGHT HANDED I AM LEFT HANDED (Please Circle)

WHAT KIND OF WORK DO YOU DO? (Please Circle) Construction Desk Job Driving Teacher
Executive/Professional Factory Homemaker Retired Sales Student

Other (Please List) ____

IF YOU ARE NOT WORKING NOW, WHEN DID YOU LAST WORK? ______/______/______

DOES IT REQUIRE LIFTING? HOW OFTEN DO YOU LIFT THESE WEIGHTS? (Please Circle)
None 10 lbs. or less 10-50 lbs. 50-100 lbs More than 100 lbs.
Rarely Frequently Constantly

AS PART OF YOUR WORK DO YOU COMMONLY? (Please Circle All Those That Apply)
Squat Push Pull Lift Overhead Climb Ladders/Stairs Reach Bend Stoop

IS THIS A WORKMAN'S COMPENSATION CASE? (Please Circle) Yes No

Company Name ______________________________ Company Phone (_______)______________

Company Address ____
STREET CITY STATE ZIP

IS THIS A LEGAL OR THIRD PERSON LIABILITY CASE? (Please Circle) Yes No

Lawyer's Name ______________________________ Lawyer's Phone (_______)______________

Lawyer's Address ____
STREET CITY STATE ZIP

WHICH JOINT(S) ARE YOU HAVING TROUBLE WITH? (Please Circle Those That Apply)
Right: Shoulder Elbow Wrist Hand Fingers Hip Knee Ankle Foot Toes
Left: Shoulder Elbow Wrist Hand Fingers Hip Knee Ankle Foot Toes
Back Left Buttock Right Buttock Left Groin Right Groin Left Thigh Right Thigh
Other (Please List) ____

____

PLEASE CIRCLE YOUR ONE MAJOR COMPLAINT ! PLEASE CHECK (✔) ANY OTHER COMPLAINTS

Aching/Soreness Thigh/Knee/Calf Pain Swelling
Popping or Crunching Noises Weakness Stiffness
Locking/Catching Limping Prolonged Driving/Sitting
Something Moving Inside Standing Buckling/Giving Away/Instability
Difficulty With: Lifting Stairs/Ladders Squatting Getting Up From a Chair Putting on Clothes/Shoes
Limited: Knee Motion Walking Standing Sports/Running Activities Work

Any Other Complaints ____

____

HAVE YOU EVER HAD A KNEE OR THIGH INJURY OR PAIN? YES NO (See Last Page for Surgery)
WHEN?____

____

ONSET OF THE PROBLEM:

Suddenly But **No Known Injury:** On ____/____/____

_______ Days Ago _______ Weeks Ago _______ Months Ago _______ Years Ago

An Injury : On ____/____/____

_______ Days Ago _______ Weeks Ago _______ Months Ago _______ Years Ago

I Don't Know When ________________ Gradually Since ______________________________________

Other____

HAVE YOU MISSED WORK/PRACTICE BECAUSE OF YOUR KNEE? Yes No

How long have you been off work? ____ days ____weeks ____ months _______ Since the Injury

If you have returned to work, when did you return? ____week(s) ago ___ month(s) ago On ____/____/____

HAVE YOU BEEN ON LIGHT OR LIMITED DUTY BECAUSE OF YOUR KNEE? Yes No

INJURED WHILE:(Please Circle All Those That Apply)

Falling | Hit By Object | Running/Jumping | Hit By Another Player

Tripping | Noncontact | Pulling/Pushing | Reaching | Slipped on Ice/Water/Oil

Twisting | Vehicle Accident | Leg/Ankle/Foot was run over

Other____

INJURED DURING:(Please Circle)

Aerobics	Basketball	Baseball	Bicycling
Football	Handball	Racquetball	Running
Soccer	Skiing	Tennis	Volleyball

Other ____

AT THE TIME OF THE INJURY , DID YOU FEEL OR HEAR A RIP, POP OR TEAR? Yes No

AFTER THE INJURY, DID THE KNEE SWELL? (Please Circle) Never <12 hours 12-24 Hours >24 Hours

---

IF THIS WAS AN INJURY ON THE JOB, PLEASE FILL OUT THIS SECTION

Injury At Work On ____________________________ Time of Day ______ AM PM

Was any equipment, machinery and/or object involved in the accident? **Yes** **No**

If yes,please explain ____

____

Was the accident reported to your supervisor and/ or employer at the time of the injury? **Yes** **No**

IF THIS WAS A MOTOR VEHICLE ACCIDENT,PLEASE FILL OUT THIS SECTION

Vehicle Accident On _____/_____/_____ Time of Day ______ AM PM

Were You? (Please Circle) Driver Passenger Pedestrian Wearing a Seatbelt? **Yes** **No**

Did you strike your head or lose consciousness? **Yes** **No**

If you were passenger,what was your position in the vehicle? ________________________________

What kind of vehicle(s) was/were involved in the accident? (Please circle your type of vehicle and place a check (✔) over the other) Truck Van Car Motorcycle

Other ____

Was the collision?: Rear end Headon "T" Type Sideswipe Struck on the Left Struck on the Right

Multiple Vehicle "Daisy Chain" Other ____

____

Was your vehicle moving when it was struck? **Yes** **No** How fast was it going? ______________________

Was the accident reported to the police? **Yes** **No**

What was the weather? ____

Did your vehicle strike another vehicle or object? **Yes** **No** Please Describe: ______________________

____

Other ____

____

IF YOU ARE EXPERIENCING **PAIN**: PLEASE ANSWER THIS SECTION.

IF NOT, PLEASE CIRCLE **NO PAIN** AND SKIP TO THE NEXT PAGE

Overall, Since It Started, Is Your Pain? (Please Circle) Getting Better Getting Worse Staying the Same

Overall, How Much is the Pain Better or Worse ? (Please Circle) 0% 10% 25% 50% 75% 90%

On Average, I have ______% Good Days ______ % Bad Days ______ % Average Days

LOCATION OF THE KNEE PAIN: (Please Circle All Those That Apply)

All Over	Inner Side	Outer Side
Front of the Knee	Kneecap	Right Behind the Kneecap
Back of the Knee	Top/Bottom of Kneecap	Deep Inside the Center of the Knee
Hip	Groin	Thigh
Shin	Ankle	Foot

Other____

FREQUENCY OF THE KNEE PAIN: (Please Circle All Those That Apply)

Recent Onset	Occassionally	Irregularly
Unpredictable	Some Days	Most/ Every Day
Constantly	At Work	Most/Every Night
Even When Resting	With or After Activity/Sports	Initially But Not Now
Getting More Frequent	Getting Less Frequent	Frequency is Unchanged

Other____

TIME OF DAY WHEN THE PAIN OCCURS: (Please Circle The MajorTime of Day and Check (✔) Any OthersThat Apply)

Morning	Late in the Day	Evening
Unpredictable	Irregular	Good & Bad Days
At Work	All Day/Constant	No Apparent Pattern to the Pains
Interrupts My Sleep	Other ______________________	

HOW OFTEN DO YOU WAKE UP AT NIGHT OR HAVE DIFFICULTY GOING TO SLEEP BECAUSE OF KNEE PAIN?

Never	Rarely/Sometimes	Most Nights
Every Night	I Can Sleep But Only When I Take Medicine	I Can't Sleep Even When I Take Medicine

BECAUSE OF MY THIGH/KNEE/LEG PAIN I HAVE TO SLEEP : (Please Circle)

I Have No Difficulty Sleeping	On My Back	On My Stomach
On the Affected Side	Sitting Up	Without Sheets Touching My Legs/Feet

THE PAIN IS:

Sharp/Knifelike	Dull	Aching
Electric Shock	Burning	Continuous
Worst in the Morning	Worst in the Evening	Soreness but not pain

Other ____

THE KNEE PAIN IS AGGRAVATED BY: (Please Circle All Those That Apply)

Nothing Specific	Climbing Up Stairs	Going Down Stairs	Squatting or Kneeling
Housework/Yardwork	With Weather Changes	Sports	Running/Jumping
Pulling/Pushing	Prolonged Standing/Walking	Twisting or Cutting	Coughing/Sneezing
Carrying Objects	Lifting	Walking on Hills/inclines/uneven ground	

Sitting too Long with Knees Bent(driving, airplane, theater or desk) Getting up from a Chair to Walk

Other____

If you have knee pain with stairs, which is worse? Up Down Both Equally Bad

Which sports make the pain worse? (Please List) ______________________________

WHAT ACTIVITIES OR POSITIONS MAKE THE KNEE PAIN BETTER?:(Please Circle All Those That Apply)

Nothing	Rest/Lying Down	Using a Walker/Crutches/a Cane
Activity	Heat	Cold/Ice
Medicine	Cortisone Injection	Activity/Moving The Knee Around
Orthotics/Arch Supports	Wide Shoes	Prescription Shoes
Physical Therapy	Avoiding High heels	A Brace

Other____

MAXIMUM WEIGHT YOU CAN PUSH/PULL: None 25-50 lbs. 100 lbs. More than 100 lbs.

MAXIMUM WEIGHT YOU CAN CARRY: (Please Circle) Weight of the Arm Only

Brief Case (5-10 lbs.) Shopping Bag (10-15 lbs.) Suitcase (25-30 lbs.) More Than 50 lbs.

KNEE RANGE OF MOTION: (Please Circle All those That Apply)

Normal Unable to Fully Straighten the Knee Unable to Fully Bend or Flex the Knee

MOBILITY OF THE KNEE: (Please Circle All those That Apply)

Able to Walk Normally Able to Walk With a Limp Able to Run Normally

Unable to Run Unable to Walk Without a Cane, Crutches,Brace or Walker

How Often Do You Limp or Need an Aid to Walk? Daily Once a Week Once a Month

Other ______________________________

MAXIMUM TIME YOU COULD SIT IN ONE PLACE IF I PUT A GUN TO YOUR HEAD! (Please Circle)

Less than 15 Minutes 15-30 Minutes 30-60 Minutes 1-2 Hours Unlimited

MAXIMUM TIME YOU COULD STAND IN ONE PLACE IF I PUT A GUN TO YOUR HEAD! (Please Circle)

Less than 15 Minutes 15-30 Minutes 30-60 Minutes 1-2 Hours Unlimited

MAXIMUM DISTANCE YOU COULD WALK IF I PUT A GUN TO YOUR HEAD! (Please Circle)

From Bed to Wheelchair Across the Room Less Than 1 Block

1 to 4 Blocks 4 Blocks to 1 Mile ________ Miles/Unlimited

Could you walk as far if you could not use an aid such as a cane or crutches? YES NO

AIDS TO WALKING CURRENTLY IN USE: (Please Circle All those That Apply)

No Aids Necessary Brace Cane Crutches Walker Wheelchair

MAXIMUM NUMBER OF STAIRS THAT YOU CAN CLIMB IF I PUT A GUN TO YOUR HEAD! (Please Circle)

None A Few Steps 1/2 Flight 1 Flight 2 or More Flights I Need the Railing

IS YOUR KNEE STIFF? (Please Circle All those That Apply)

Never Always After Activity or Sports With Walking

With Weather Changes In the Morning At the End of the Day When Driving or Sitting

Other ______________________________

DOES THE KNEE SWELL? (Please Circle All Those That Apply)

Never At First But Not Now Just Started Occasionally

Frequently Daily/Constantly Only Once or Twice Unpredictable

Worst at the End of the Day Worst in the Morning With Squatting or Kneeling At The Present Time

When Going Up/Down Stairs When the Weather is Bad When Pivoting/Twisting/Cutting

When Walking On Level Ground After Giving Out or Buckling After Exercise or Use of the Joint

Other ______________________________

DOES THE KNEE GET "STUCK" , "CATCH" OR "LOCK UP"? (Please Circle All Those That Apply)

Never At First But Not Now Just Started Ocassionally

Frequently Daily/Constantly Only Once or Twice Unpredictable

When Walking Twisting/Cutting Squatting/Kneeling Catches But Does Not Truly Lock

How Often Does This Happen? Daily ________ Weekly ________ Monthly ________

How Many Total Times Has This Happened? ________

Other ______________________________

DOES THE KNEE GIVE OUT, COLLAPSE OR BUCKLE? (Please Circle All Those That Apply)

Never At First But Not Now Just Started Ocassionally

Frequently Daily/Constantly Only Once or Twice Unpredictable

At The Present Time Going Up/Down Stairs Feels Like It Might Buckle But Does Not Actually Collapse

With Squatting/Kneeling With Pivoting/Twisting/Cutting

When Walking On Level Ground When Walking On Uneven Ground/Inclines/Hills

How Often Do The Knee(s) Buckle? Daily ________ Weekly ________ Monthly ________

How Many Total Times Has This Happened? ________

Other ______________________________

WHEN THE KNEE(S) GIVE OUT OR BUCKLE: (Please Circle) I Fall Down I Can Catch Myself

DO YOU FEEL Cracking,Crunching,Grinding,Grating,Poppping,Snapping or “Funny Noises” IN THE KNEE?
(Please Circle All That Apply)
Never When Squatting When Walking When Climbing Stairs Getting Up From a Chair
The Noises Are Painless The Noises Are Painful The Noises Are Getting Worse
The Noises Are Old I Can Feel Them With My Hand The Noises Started with the Current Problem

DO YOU HAVE WEAKNESS IN THE LEGS? YES NO
Where?____________________

ALIGNMENT OF THE KNEE: (Please Circle All those That Apply)
No Change in Alignment Straight Knock-kneed
Bowlegged Becoming More Knock-kneed Becoming More Bowlegged

ACTIVITIES YOU ABSOLUTELY CAN NOT DO BECAUSE OF THE KNEE (Please Circle All those That Apply)
None Put on clothes Shopping Housework Work at my job Yard Work Sleep
Lifting Sitting/Driving Standing Squatting Carrying Putting on Shoes or Socks
Sports Running Stairs
How long have you been off work? ________ days ________weeks _______ months
Recreational activities I enjoy (Please List) ____________________
Other ____________________

DO YOU HAVE KNEE PAIN WITH LIFTING:

A Telephone Book or 1 Pint of Milk (1-2 lbs.)	Yes	No
A Sack of Flour or 1 Gallon of Milk (5-10 lbs.)	Yes	No
A Small Child (25-50 lbs.)	Yes	No
50-100 lbs.	Yes	No
More Than 100 lbs	Yes	No

PLEASE CIRCLE THE NUMBER THAT CORRELATES BEST WITH HOW FAR YOU ARE FROM NORMAL TOWARD THE WORST POSSIBLE SITUATION YOU CAN IMAGINE OR HAVE EVER SUFFERED

0 1-2 3-4 5-6 7-8 9-10

0 = No pain or limitation at all. 10 = The worst possible pain or limitation that you can ever imagine.

How bad is your pain today?	0	1	2	3	4	5	6	7	8	9	10
How bad is the pain at the worst its ever been?	0	1	2	3	4	5	6	7	8	9	10
How bad is the pain at the best its ever been?	0	1	2	3	4	5	6	7	8	9	10
Does the pain interfere with your lifestyle?	0	1	2	3	4	5	6	7	8	9	10
Does the pain interfere with your work?	0	1	2	3	4	5	6	7	8	9	10
Do you have pain lying in bed or at rest?	0	1	2	3	4	5	6	7	8	9	10

IF YOU ARE A RUNNER,HOW MANY TIMES A WEEK DO YOU RUN? __________ Times per Week
HOW MANY MILES DO YOU RUN AT A TIME? ___________ Miles at a Time
HAVE YOU EVER HAD AN ARCH SUPPORT OR ORTHOTIC PRESCRIBED FOR YOU? Yes No
Did They Help? Yes No
HAVE YOU EVER BEEN TOLD YOUR LEG LENGTHS WERE UNEQUAL AND YOU NEEDED A HEEL LIFT? Yes No
WHICH SPORTS DO YOU (OR WOULD LIKE TO) PARTICIPATE IN? ARE LIMITED IN THEM? (Please List)
5HAVE YOU OR DO YOU PARTICIPATE IN COMPETITIVE SPORTS AND AT WHAT LEVEL? (Please List)
____
HAVE YOU EVER BROKEN A BONE, DISLOCATED A JOINT OR HAD ANY OTHER SERIOUS ORTHOPEDIC INJURY THAT DID NOT REQUIRE SURGERY? (Please List and Date Each)
____
____

HAVE YOU TAKEN ANY MEDICATIONS FOR THE PAIN? **YES** **NO**

(Please Circle Your CURRENT Medications and Check (✔) Any OthersThat You Have Taken in the Past)

Pain Medication	Antiinflammatory Drugs		Muscle Relaxants/Neuro Drugs
Tylenol (acetaminophen)	Aspirin	Daypro(oxaprozin)	Flexeril (cyclobenzaprene)
Tylenol #3 (codeine)	Motrin/Ibuprofen/Advil	Clinoril (sulindac)	Neurontin (gabapentin)
Vicodin/Norco (hydrocodone)	Naprosyn(Aleve)	Lodine(etodolac)	Lyrica(pregabalin)
Oxycontin/Oxycodone	Celebrex (celecoxib)	Limbrel	Soma (carisoprodal)
Percodan (oxycodone)	Mobic (meloxicam)	Indocin(indomethacin)	Dantrium(dantrolene)
Darvocet-N-100(propoxyphene)	Voltaren(diclofenac)	Relafin(nabumetone)	Robaxin(methocabamol)
Ultram (tramadol)	Feldene (piroxicam)	Nalfon (fenoprofen)	Skelaxin(metaxalone)
Duract (bromfenac)	Trilisate (trisalicylate)	Glucosamine	Requip (ropinorole)

Other ____

Have you ever had a Cortisone injection or a Prednisone/Medrol dose pack? Yes No How Many? 1 2 3 4 5 >5

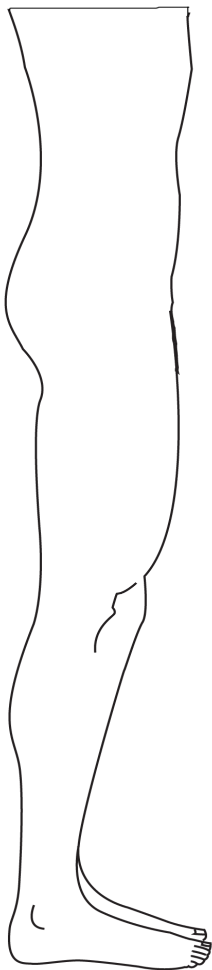
Have you ever had a Hyaluronic Acid Injections (Synvisc, Hyalgan? Yes No How Many? 1 2 3 4 5 >5

Do you use any Herbal Medicine? ______________________________

DOES THE MEDICATION HELP? Yes No Only A Little Bit

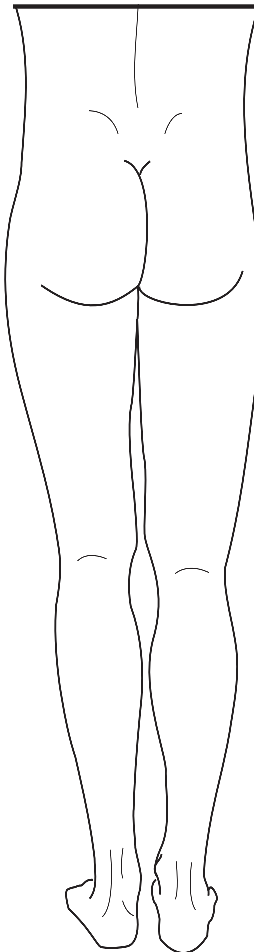
WHERE IS YOUR PAIN? (Please mark on the drawings where you feel the specific type pain or sensation)

Burning XXXX Throbbing ✔✔✔✔ Sharp ////////// Aching ●●●●● Numbness ✻✻✻✻

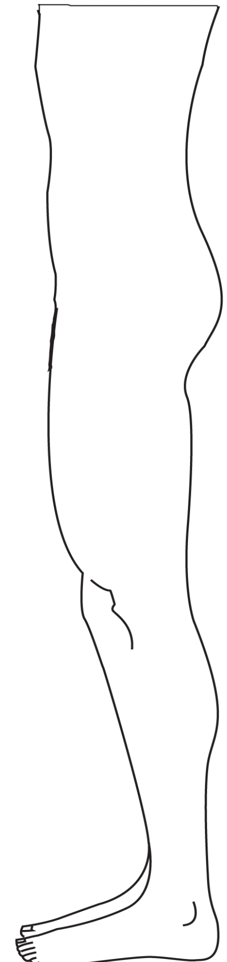


Right

Front



Back



Left

HAVE YOU BEEN TREATED FOR THIS PROBLEM BY YOUR FAMILY PHYSICIAN? YES NO

Name ________________ When ________________

Diagnosis________________ Treatment________________

HAVE YOU BEEN TREATED FOR THIS PROBLEM BY AN ORTHOPEDIC SURGEON? YES NO

Name ________________ When ________________

Diagnosis________________ Treatment (See Below)

HAVE YOU BEEN TREATED FOR THIS PROBLEM BY A CHIROPRACTER OR NAPROPATH? YES NO

Name ________________ When ________________

Diagnosis________________ Treatment________________

HAVE YOU EVER HAD X-RAYS TAKEN OF YOUR KNEES? YES NO

When ________________ Where ________________

Results ________________

HAVE YOU HAD AN ARTHROGRAM (dye test) DONE? YES NO

When ________________ Where ________________

Results ________________

HAVE YOU HAD A CAT SCAN OR MRI DONE OF YOUR KNEE? YES NO

When ________________ Where ________________

Results ________________

WERE YOU TREATED FOR THIS PROBLEM IN AN EMERGENCY ROOM? YES NO

Hospital ________________ When ________________

Diagnosis ________________ Treatment ________________

HAVE YOU EVER HAD PHYSICAL THERAPY (PT), A BRACE OR CORSET FOR YOUR KNEE?
YES NO

When ________________ Where ________________

Results ________________

HAVE YOU EVER HAD SURGERY FOR YOUR KNEE? YES NO

#1 When ________ Hospital ________________

Open Surgery______ Arthroscopic Surgery _____ Doctor ________________

Procedure ________________

Results________________

#2 When ________ Hospital ________________

Open Surgery______ Arthroscopic Surgery _____ Doctor ________________

Procedure ________________

Results________________

#3 When ________ Hospital ________________

Open Surgery______ Arthroscopic Surgery _____ Doctor ________________

Procedure ________________

Results ________________

#4 When ________ Hospital ________________

Open Surgery______ Arthroscopic Surgery _____ Doctor ________________

Procedure ________________

Results ________________

THANK YOU FOR PATIENCE IN FILLING OUT THIS FORM!