OSNC Orthopaedic Specialists of North County

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Knee Evaluation

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 yo 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 were you able to walk prior to the pain? _____
Do you avoid physical activity such as walking long distances, shopping, walking up stairs? ☐ yes ☐ no
Do you have regular exercise program? ☐ yes ☐ no
What is your amount of pain at rest? 1 2 3 4 5 6 7 8 9 10 (highest)
Do you have pain during or immediately after activity? Circle one: 1 2 3 4 5 6 7 8 9 10 (highest)
How do you consider your pain: ☐ annoying ☐ inconvenient ☐ restricting ☐ disabling
Past history of knee problems? _____
Prior knee surgeries? ☐yes ☐no Which knee? ☐L ☐ R Procedure(s): _____
When: _____Where: _____ Doctor: _____
Is this appointment for a 2nd opinion? ☐yes ☐no
Please write a brief description of your symptoms and how your injury happened: _____
_____
_____

	Which knee:		**Please check inside box that applies to the frequency**		
Do you have:	Left	Right	During activity	Weekly	Rarely
Locking					
Giving way					
Catching					
Swelling					
Pain at night					
Morning stiffness					
Clicking					
Popping					
Grinding					
Difficulty w/ stairs					
Uneven terrain					
Running					
Kneeling					

Which treatments have you tried?

Chondroitin/glucosamine or other cartilage supplements: ☐ yes ☐ no • Physical therapy: ☐yes ☐ no
Steroid injections: ☐ yes ☐ no Hyaluronic injections: (Hyalgan, Supartz, Synvisc, etc.): ☐ yes ☐ no
Medications (Celebrex, Aleve, Tylenol, etc.): ☐yes ☐ no Ice: ☐yes ☐no • Bracing: ☐ yes ☐ no
Shoe inserts: ☐ yes ☐ no • Activity modification: ☐ yes ☐ no Cane or walking stick: ☐ yes ☐ no