

UTAH ORTHOPAEDIC SPECIALISTS
Knee Questionnaire

Name: _____ Date: _____

1. Do you have a history of a deep vein clot or pulmonary embolism? _____
2. What happened to your knee? _____

3. When did it happen? Date: _____ Which knee? L or R
4. How long have you had pain? Years: _____ Months: _____ Weeks: _____
5. What activities cause pain? _____
6. Type of pain/discomfort (e.g., achy, burning, sharp) _____
7. The pain is (circle one): mild; moderate; severe
8. How long does it last? _____ When does it occur? _____
9. Any specific activity? _____
10. What makes it worse? _____
11. What makes it better? _____
12. Associated symptoms (e.g., clicking, popping, catching, etc.)? Describe them: _____

13. What treatment have you had in the past (include physical therapy)? _____
14. Are you (please circle) better, worse, or the same since your treatment began? _____
15. Do you have pain in your knee at night? Yes or No
16. Have you ever had any surgery done on your knee? Yes or No
17. Have you ever had a cortisone injection in your knee joint? Yes or No
If so, how many times? _____
When were the shots given? Date: _____
How long did the injection last? _____
18. What athletic activities do you participate in? Please list: _____
19. Who referred you to this office? _____
20. How bad is your pain today (mark on the line with an X)?

No pain at all

Pain as bad as it can be