NEWPORT
ORTHOPEDIC INSTITUTE

NAME:_____ AGE:_____ SEX: M/F DATE:__/__/__ Occupation: _____

Affected Knee (please circle): Right Left

Do you have pain? Yes No If yes, for how long?:_____
Did you have a specific injury? Yes No If yes, when? Date: _____
Have you had recurrent injuries? Yes No If yes, how many?:_____
Did you injure your knee playing sports? Yes No If yes, sport?:_____
Does or has your knee given out? Yes No If yes, number of times:_____
Does your knee swell? Yes No How often?_____
On a scale of 1-10, how severe is your pain at worst?_____

Please briefly describe the injury and activity at the time of the original injury and currents symptoms:

_____

_____

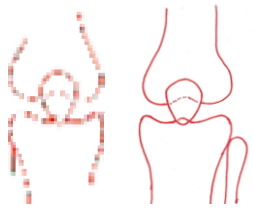
_____

What are your most common physical activities?

_____

_____

Do you have pain going up or down stairs, or squatting? Yes No Right Left
Where do you have pain in the knee-please circle (front, back, inside, outside, all over)
Does your knee feel stiff after sitting? Yes No
Does your knee lock? Yes No
Does your knee give out or feel unstable? Yes No
Does your knee click or pop? Yes No
Do you have pain with twisting type activities? Yes No



What medications are you taking for your pain? (ex: Vicodin, Ibuprofen, Aleve)
_____
Have the medications helped? Yes No
Have you tried icing your knee? Yes No
Have you done physical therapy for your knee? Yes No
Have you had knee surgery? Yes No
Has your knee been injected? Yes No With what/when?_____
Did the injections help? Yes No If so, for how long?_____
If yes, please describe what was performed and when: _____

_____

_____

Do you walk with: (circle one) No Crutches or Cane Crutches Cane Walker
How far can you walk? Unlimited Less than 1 block 1-5 blocks 5-10 blocks Unable

Do you have any numbness or tingling? Yes No If yes, where:_____