

	PENINSULA ORTHOPAEDIC ASSOCIATES	Name:	
	New Problem	POA ID#:	
	KNEE	Date:	
		Birth Date:	Age:
		Primary Care Physician:	

What is the name of the medical provider who sent you here today? _____

	RIGHT	LEFT
Which knee hurts?	<input type="checkbox"/> Right only <input type="checkbox"/> Left only <input type="checkbox"/> R=L <input type="checkbox"/> R more than L <input type="checkbox"/> L more than R	
When did the problem start?		
Did you have an injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what injury did you have?		
How bad is the Pain	None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible	None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible
What does the pain feel like?	<input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning	<input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning
Where is the pain?	<input type="checkbox"/> Front <input type="checkbox"/> Inner side <input type="checkbox"/> outer side <input type="checkbox"/> Back	<input type="checkbox"/> Front <input type="checkbox"/> Inner side <input type="checkbox"/> outer side <input type="checkbox"/> Back
Is the pain?	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent
Is the pain?	<input type="checkbox"/> Improving <input type="checkbox"/> Worsening <input type="checkbox"/> Unchanged	<input type="checkbox"/> Improving <input type="checkbox"/> Worsening <input type="checkbox"/> Unchanged
What makes it worse?	<input type="checkbox"/> Movement <input type="checkbox"/> Keeping Still	<input type="checkbox"/> Movement <input type="checkbox"/> Keeping Still
Is there any?	<input type="checkbox"/> Swelling <input type="checkbox"/> Buckling <input type="checkbox"/> Popping <input type="checkbox"/> <input type="checkbox"/> Stiffness <input type="checkbox"/> Grinding	<input type="checkbox"/> Swelling <input type="checkbox"/> Buckling <input type="checkbox"/> Popping <input type="checkbox"/> <input type="checkbox"/> Stiffness <input type="checkbox"/> Grinding
Has your knee cap ever dislocated? How many times?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Does your knee feel unstable?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What treatments have you tried?	<input type="checkbox"/> None (rest) <input type="checkbox"/> medications (Type:_____) <input type="checkbox"/> Injections (how many?____) <input type="checkbox"/> Physical Therapy _____ <input type="checkbox"/> Surgery (Type:_____)	<input type="checkbox"/> None (rest) <input type="checkbox"/> medications (Type:_____) <input type="checkbox"/> Injections (how many?____) <input type="checkbox"/> Physical Therapy _____ <input type="checkbox"/> Surgery (Type:_____)
How would you rate your knee prior to this onset of pain?	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Did you hurt yourself at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you involved in litigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

For workers' compensation and litigation patients only		
	RIGHT	LEFT
Did you have pain before the injury at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, when did it start?		
How bad was the pain prior to the work /litigation injury?	None 1 2 3 4 5 6 7 8 9 10 Worst	None 1 2 3 4 5 6 7 8 9 10 Worst
How long after the work /litigation injury did the pain start?		