Bahri Orthopedics & Sports Medicine Clinic, P.L.

Knee History

Name:_____ Date:_____ Age: _____

Knee Problem: _____ ○ Right ○ Left

Date of Onset:_____ Injury: ○ Yes ○ No *(Describe Injury)* _____

How Did Pain or Problem Begin? _____

_____

_____

_____

Symptoms

Is your knee problem	intermittent	constant
Soreness/Aching	○ Yes	○ No
Pain	○ Yes	○ No
Popping, clicking, grinding	○ Yes	○ No
Loss of motion	○ Yes	○ No
Stiffness	○ Yes	○ No
Swelling	○ Yes	○ No
Weakness	○ Yes	○ No
Tenderness	○ Yes	○ No
Difficulty going up and down stairs	○ Yes	○ No
Locking	○ Yes	○ No
Giving way	○ Yes	○ No
Does knee pain wake you or keep you awake	○ Yes	○ No
Past knee problems	○ Yes	○ No
Are you in good general health	○ Yes	○ No
	○	○

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