BRISBANE KNEE & SPORTS SURGERY

KNEE QUESTIONNAIRE

Name: **Date:**

Age: **Birth Date:**

Is this Workcover: Y N **What is your job description:**

What is the problem with your Knee?

Is the current problem a result of :

Car Accident		If Other please specify:
Work injury		
Sports Injury		
Other		

HISTORY

Which knee is the problem? R L Both

When did the problem start?

Have you had previous problems with your knee?

What problems are you experiencing? Please tick all that apply

Pain		
Stiffness		
Catching/locking		
Weakness		
Swelling		
Limited Motion		
Instability / dislocation		
Grinding / popping		
Clicking		

What makes the problem better?

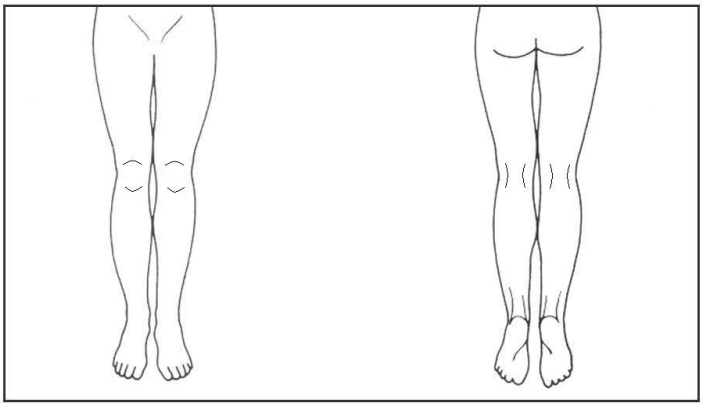
What makes the problem worse?

PAIN

Quality of pain:

Throbbing		
Sharp		
Dull		
Aching		
Stabbing		
Burning		

Location of pain: Please mark location on diagram.



How severe is your pain? Please mark on the score below

NO PAIN 0_1_2_3_4_5_6_7_8_9_ 10 SEVERE PAIN

Frequency of pain:		
Rarely		
Occasionally		
Frequently		
Constantly		
When does the pain occur?		
Morning		
Day		
Evening		
Night		
Interrupts sleep, if so how many times?		
Weather change		
When is the pain made worse?		
Resting		
At work		
Driving		
Other		
When is the pain relieved?		
Nothing		
Rest		
Activity		
Medication		
Injection		
Physiotherapy		
Ice		
Heat		

ACTIVITIES

Do you have difficulty with the following activities:

Activity	Right Leg	Left Leg
Kneeling	**Y N**	**Y N**
Squatting	**Y N**	**Y N**
Ascending stairs	**Y N**	**Y N**
Descending stairs	**Y N**	**Y N**

PRIOR TREATMENT FOR THIS PROBLEM

Have you seen a specialist for this problem Y N if yes, whom:

What was the diagnosis?

What was their treatment?

Type of treatment	Type	How often	Period of time	Help Hurt No effect
Analgesics				
Anti-inflammatories				
Cortisone injections				
Rest				
Chiropractic				
Massage therapy				
Acupuncture				
Bracing of the knee				

Physiotherapy treatment? Y N if yes, please detail below.			
Day / Month / Year	**Physiotherapist**	**Type of Physio**	**Results**

Previous knee surgery? Y N if yes, please detail below.			
Month/Day/Year	**Surgeon**	**Type of surgery**	**Results**

X – RAYS / SCANS

X – rays / ultrasound: Y N If yes, please complete below
Day/ Month / Year

Previous MRI /CT scan : Y N If yes, please complete below			
Month / Day / Year	**Location**	**Type of scan**	**Results**

MEDICAL HISTORY

Please circle		
Do you suffer from hip problems?	**N**	**Y**
Do you have any back problems?	**N**	**Y**
Do / did you have any heart problems?	**N**	**Y**
Do / did you have ulcers / gastritis?	**N**	**Y**
Do / did you have diabetes?	**N**	**Y**
Do / did you have liver problems / hepatitis?	**N**	**Y**
Do / did you have kidney disease?	**N**	**Y**
Do / did you have cancer?	**N**	**Y**
Do /did you have blood clots?	**N**	**Y**
Do /did you smoke cigarettes? (if yes, how many)	**N**	**Y**
Do / did you drink alcohol? (if yes, how many units per week)	**N**	**Y**
Do you suffer from any allergies?	**N**	**Y**

Please use the space below to explain any of the above