Name: **KNEE RECHECK**

Current Symptoms:
☐ Feeling great
☐ Much better
☐ Somewhat better
☐ Same as it was
☐ Worse

Pain:
☐ Intermittent knee pain
☐ Constant knee pain

Location of Pain:
☐ The front of the knee
☐ The inside of the knee
☐ The outside of the knee
☐ The back of the knee
☐ All over

Quality of Pain:
☐ No pain
☐ Achy
☐ Burning
☐ Dull
☐ Sharp
☐ Other:_____

Instability with:
☐ Walking
☐ Stairs
☐ Running
☐ Sports
☐ Pivoting on the knee

Walking Ability:
☐ Household
☐ 1-2 blocks
☐ 5-10 blocks
☐ Not limited

Walking Aids:
☐ Cane
☐ Crutches
☐ Walker
☐ Shopping cart
☐ Brace

Severity of Pain:
☐ No pain today
☐ Severe
☐ Moderate
☐ Mild
☐ Scale of 1-10 _____

Swelling:
☐ Denies swelling
☐ Occasional swelling
☐ Swelling with activity

Sports Limitations:
☐ Has no limitations
☐ Difficulty participating in:
_____
☐ Unable to participate in:
_____

Other Symptoms:
☐ Locking – unable to straighten or bend
☐ Cracking
☐ Popping
☐ Catching
☐ Clicking
☐ Weakness
☐ Morning "stiffness"

Injection (only by Dr. Sima):
☐ Has been very beneficial
☐ Helped somewhat
☐ No effect
☐ Lasted _____ weeks/ days/ hours

Medications Currently Taking:
_____
_____

Work Status:
☐ Full duty
☐ Light duty
☐ Out of work
☐ Retired
☐ Disabled
☐ Homemaker

Stiffness: The following question concerns the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?
   ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

Pain:
What amount of knee pain have you experienced the **last week** during the following activities?

2. Twisting/Pivoting your knee
   ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

3. Straightening knee fully
   ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

4. Going up or down stairs
   ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

5. Standing upright
   ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

Function, daily living: The following questions concern your physical function. By this we mean your ability to move around and look after yourself. Please indicate the degree of difficulty you've experienced in the **last week**

6. Rising from sitting
   ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

7. Bending to floor/pick up an object
   ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme