



**KNEE
PATIENT INTAKE FORM**

DIVISION OF SPORTS MEDICINE

Howard Luks, M.D., Chief
Daniel Zelazny, M.D., Attending

Name _____ Date _____

Age _____ Occupation _____

1. Who referred you to us? Name _____ Phone _____

Address _____

2. Who is your Internist or Primary Care Physician? Name _____

Phone _____ Address _____

3. Chief complaint or current illness? _____

Where do you experience this problem?

Is this a problem with your: right knee left knee

How long have you had this problem? _____

Is your problem getting worse better same

Was this the result of an injury? yes no

If yes, please describe: _____

If yes, is this a workers' compensation injury? yes no (if **yes**, please skip to **question 5**)

4. Work-related injury:

Job title: _____ How long with this employer? _____

Date of injury: _____ Are you: Off work Modified duty Full duty

If not full duty now, on which date did you last work full duty: _____

5. If pain is one of your complaints, please complete the following. If not, skip to question 6.

a. Is your pain in: Front Back Inside of knee Outside of knee Behind kneecap

b. Rate the average intensity of your pain/discomfort. (0= no pain, 10= severe pain)

0 1 2 3 4 5 6 7 8 9 10

c. Describe your pain:

Intermittent Constant Dull Sharp Throbbing Tight Burning Tingling

6. Timing: Is your problem worse at any particular time of the day?

Morning Afternoon Evening Night All the time

Does your pain allow you to sleep comfortably? Yes No

7. Activity-related symptoms:

Is your knee comfortable at rest?	YES	NO
Can you walk without using supports (brace, crutches, cane, etc.)?		
Can you walk without a limp?		
Can you walk without your knee locking or catching?		
Can you walk up one flight of stairs?		
Can you walk up five flights of stairs?		
Can you run the length of one block?		
Can you run one mile?		
Does your knee allow you to pivot, change directions, or jump without giving way?		
Can you perform your normal activities of daily living (other than work or sport)?		
Does your knee allow you to participate in sports?		
Can you participate in sports at the level of competition you desire?		
Does your knee allow you to work full-time at your job?		

8. Do you ever have any of these additional symptoms?

	YES	NO	DESCRIBE
Stiffness			
Numbness			
Swelling			
Weakness			
Pain			
Instability			
Roughness			
Other			

9. Have you tried any of the items below? If so, did they help?

	YES	NO	DESCRIBE	Helped	Didn't help
Medication			Type:		
Physical Therapy			For how long? Date of last visit:		
Injections			Where?		
Other:			Describe:		

10. Please list all medications you currently use with dosage and frequency:

11. Do you have any allergies? Yes No If yes, please list:

12. Have you ever had problems with any of the following? If yes, please describe.

	YES	NO	DESCRIBE:
Heart problem			
Breathing, lungs			
High blood pressure			
Cancer			
Diabetes			
Arthritis			
Hepatitis, AIDS, TB			
Liver problem			
Polio			
Epilepsy or seizures			
Bowel or colon			
Bladder problem			
Kidney problem			
Balance problem			
Numbness or tingling			
Blackout or fainting			

13. Please list all past surgeries and hospitalizations:

REASON	DATE	PHYSICIAN

14. Have you ever had problems with general anesthesia? YES NO

15. Do you drink alcohol? YES NO How much weekly? _____

16. Do you smoke? YES NO How much daily? _____ For how long? _____

17. Marital Status: Single Married Divorced/Separated Widowed

18. Do you:

	YES	NO	
Have children?			How many?
Live alone?			If no, with whom?
Have a special diet?			Describe:
Use recreational drugs?			Describe:
Exercise regularly?			How often?

19. Sports or hobbies:

20. Family history:

	ALIVE	DECEASED	AGE	HEALTH	CAUSE OF DEATH
Father					
Mother					
Sibling					
Sibling					
Sibling					
Sibling					

21. Your height _____ Your weight _____

Thank you for your time in completing this information!

Reviewed by: _____, M.D. Date _____