



CONNECTICUT  
CENTER FOR  
ORTHOPEDIC  
SURGERY, LLC

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Name \_\_\_\_\_

Date \_\_\_\_\_

## KNEE SURVEY

Knee evaluated                      Right                      Left                      Both  
Is this work related?               Yes                       No

What is the problem with your knee?

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Is the problem getting               worse               better               staying the same?  
Is this related to an injury?       Yes       No  
If yes, describe how it happened.

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Which word best describes your pain?     None     Mild     Moderate     Severe

Select one statement below regarding your knee pain.

- Normal function:** I can do all activities of daily living, work and sports activities that I did before my knee problem.
- I have **mild limitations** in sports and work and activities of daily living.
- I have **moderate limitations** in activities of daily living. No sports possible.
- I have **severe limitations**. Cannot do usual work or lifting. No sports.
- Complete disability** of the knee.

Where is the pain?                       Inner side     Front of knee cap     Outer side     Back of knee     All over

How often do you get pain?               Never     Monthly     Weekly     Daily     Always

How bad is your pain today?              No pain > 0    1    2    3    4    5    6    7    8    9    10 < Worst pain imaginable

Describe the pain               Constant     Comes and goes  
 Dull     Sharp     Throbbing     Burning     Aching

Do your knee               Pop     Click     Catch / locking     Give way (knee collapses or buckles)     Swell  
 Grind

Check all that apply               Knee stiffness in the morning  
 Knee stiffness later in the day  
 Stiffness after sitting, lying or resting

Have you had previous x-rays or MRI s of the shoulder?

When \_\_\_\_\_

Where \_\_\_\_\_

Have you had previous treatment for this condition?

Yes

No

When \_\_\_\_\_

Who \_\_\_\_\_

Physical therapy

Medication

Injections

Other

Have you had previous surgery for this condition?

When \_\_\_\_\_

Who \_\_\_\_\_

What kind of surgery \_\_\_\_\_