

**Knee Intake Survey**  
**Brian J. Cole, MD, MBA**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Today's Date \_\_\_ / \_\_\_ / \_\_\_

Email Address \_\_\_\_\_

**Information regarding your current knee problem:** When did your knee problem begin? \_\_\_ / \_\_\_ / \_\_\_

Is your problem to the: Right knee \_\_\_ Left Knee \_\_\_ Both Knees \_\_\_

Work related injury? Yes \_\_\_ No \_\_\_ If YES, date injury reported \_\_\_ / \_\_\_ / \_\_\_

**Please describe your knee problem:**

1. Problem with your knee: \_\_\_\_\_
2. Was this a result of an injury? Yes \_\_\_ No \_\_\_ Was it: Gradual \_\_\_ Sudden \_\_\_  
If YES, describe exactly what happened: \_\_\_\_\_  
\_\_\_\_\_
3. Location of your knee pain:
  - a. Inner side \_\_\_ Outer side \_\_\_ Front \_\_\_ Back \_\_\_ All over the knee \_\_\_
4. Does the knee swell? Yes \_\_\_ No \_\_\_ Does the knee feel unstable? Yes \_\_\_ No \_\_\_
5. Do you have mechanical symptoms such as locking or catching? Yes \_\_\_ No \_\_\_
6. Is your knee problem getting: Worse \_\_\_ Better \_\_\_ Staying the same \_\_\_
7. Date and results if know of imaging studies performed for your knee:
  - a. Xrays \_\_\_\_\_
  - b. MRI \_\_\_\_\_
  - c. Other \_\_\_\_\_
8. Have you had any of the following non-operative treatment to date:
  - a. Physical Therapy: Yes \_\_\_ No \_\_\_  
If YES, duration and response to PT: \_\_\_\_\_
  - b. Non-steroidal anti-inflammatories (NSAIDS): Yes \_\_\_ No \_\_\_  
If YES, name of NSAID and response to NSAID: \_\_\_\_\_
  - c. Cortisone injections: Yes \_\_\_ No \_\_\_  
If YES, date(s) and response to cortisone injections: \_\_\_\_\_
  - d. Hyaluronic acid injections: Yes \_\_\_ No \_\_\_  
If YES, date(s) and response to Hyaluronic acid injections: \_\_\_\_\_
9. Have you had any surgical procedures on the knee?: Yes \_\_\_ No \_\_\_  
If YES, please provide dates, procedure description and surgeon name.
  - i. Date: \_\_\_ / \_\_\_ / \_\_\_ Procedure: \_\_\_\_\_ MD Name: \_\_\_\_\_
  - ii. Date: \_\_\_ / \_\_\_ / \_\_\_ Procedure: \_\_\_\_\_ MD Name: \_\_\_\_\_
  - iii. Date: \_\_\_ / \_\_\_ / \_\_\_ Procedure: \_\_\_\_\_ MD Name: \_\_\_\_\_
  - iv. Date: \_\_\_ / \_\_\_ / \_\_\_ Procedure: \_\_\_\_\_ MD Name: \_\_\_\_\_

## Pain Questions

Do you currently have pain in your knee? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please list the average intensity of pain on scale of 0-10 over the last 7 days  
(0=Normal and 10 = severe pain) \_\_\_\_\_

How often do you experience pain in your knee? Never \_\_\_\_\_ Intermittent \_\_\_\_\_ Constant \_\_\_\_\_

Is there anything that helps to alleviate your knee pain? \_\_\_\_\_

Do you ever take pain medication for your knee pain? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please list:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please describe amount of knee pain experienced during the last few weeks with the following activities:

	NONE	MILD	MODERATE	SEVERE	EXTREME
Twisting/pivoting on knee					
Straightening knee fully					
Bending knee fully					
Walking on flat surface					
Going up or down stairs					
At night while in bed					
Standing upright					
Sitting or lying					

Please list any additional information that you feel would be important for us to know regarding the condition of your knee including what your specific goals and expectations are related to your treatment outcomes:

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