**Bay Area Surgical Specialists**
**Benjamin Busfield M.D., F.A.A.O.S.**

**Orthopedic Surgery and Sports Medicine**

**KNEE COMPLAINT:**

Name: _____ Date: _____

Profession: _____

**Which knee hurts:** □Left □Right □Both

**How long has the knee hurt**? _____ Months or _____ Years

**Any past knee injuries**? □Yes □No

**Any past knee surgeries**? □Yes □No If yes, what year and what surgery was done?

_____

**Pain (rate from 0-10, 10 is worst, 0 is no pain)** 0 1 2 3 4 5 6 7 8 9 10

**Describe pain**: □ Burning/tingling □ Deep ache □ Stabbing □Other:_____

**Pain location**: □ Along inside □ Along outside □ Front under knee cap □ Back of knee

**Associated symptoms:** □ Locking □ Clicking □ Stiffness □ Unstable knee

**Any recent treatment?** Anti-inflammatory meds □Yes □No Physical Therapy □Yes □No

Chiropractor □Yes □No Ice □Yes □No Injections □Yes □No

**What makes pain better?** Rest from activity □Yes □No Pain medications □Yes □No

Physical Therapy □Yes □No Ice □Yes □No

**What makes pain worse?** Walking □Yes □No Running □Yes □No Lifting □Yes □No

Kneeling □Yes □No Work □Yes □No Using stairs □Yes □No

Athletics □Yes □No Sitting □Yes □No Standing □Yes □No

**Is your walking limited?** □Yes □No

**If yes, how many city blocks can you walk _____**

**Do you use any aides?:** Cane □Yes □No Walker □Yes □No Wheelchair □Yes □No

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