Dirk R. Diefendorf, M.D.
ORTHOPEDIC SURGERY - SPORTS MEDICINE

INITIAL KNEE HISTORY

NAME____Age:_____________Date:______________

Date Of Onset of Pain/Knee Injury:______________________________ LEFT KNEE RIGHT KNEE

Any past history of knee problems/injuries?____
____

Please Describe What Happened to Your Knee:____
____
____
____
____
____

Medications taken for your knee:____
____
____

Symptoms:

Did you hear a POP or feel something?	YES	NO		
Did your knee swell?	NO	Immediately	2-6hours	Next Day
Were you able to continue sports/work?	YES	NO		
How much pain?	NONE	MILD	MODERATE	SEVERE
Were you able to straighten your leg?	YES	NO		
Do you have clicking or snapping?	YES	NO		

Treatment:

Did you see a Physician?	YES	NO		Who?_______________________________
Did you have Xrays/MRI scan?	YES	NO	BOTH	Where?_____________________________
Did you get a brace?	YES	NO		
Did you get crutches?	YES	NO		
Did you receive physical therapy?	YES	NO		
Have you had surgery on this knee?	YES	NO		When?______________________________

SYMPTOMS: PLEASE **CHECKMARK** AND DETAIL CURRENT OR RECENT SYMPTOMS REGARDING YOUR KNEE

Location of Pain? ____

Kneeling Stairs Squatting Standing Swelling

Giving way/Instability Grinding Catching/Locking Stiffness Twisting/Pivoting

NOTES for Doctor only:____
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