MILLER ORTHOPEDIC SPECIALISTS

HIP/KNEE QUESTIONNAIRE

Name:_____ Date of Birth:_____ Date:_____

Problem with:
☐ Left Knee ☐ Left Hip
☐ Right Knee ☐ Right Hip
☐ Both Knees ☐ Both Hips

Onset of Problem:
☐ Gradual
☐ Accident/Injury
☐ Sports—Date: _____
☐ Work—Date: _____
☐ Other _____

Have you had prior injury to knee/hip?
☐ Yes ☐ No

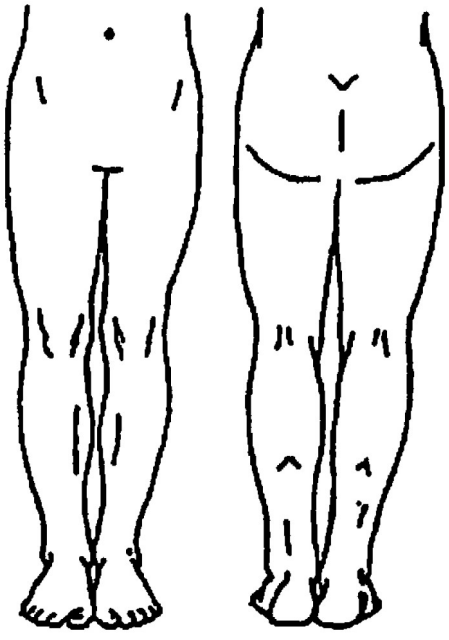
Activities:
☐ Unable to work
☐ Unable to perform activities of daily living
☐ Unable to participate in sports/recreation

Frequency of Pain:
☐ Occasional ☐ Constant
☐ Wakes you at night

Amount of Pain:
☐ Mild ☐ Moderate ☐ Severe

Pain Worsened by:
☐ Twisting ☐ Walking
☐ Sitting ☐ Running
☐ Exercise or Physical Therapy

Please Mark Areas of Pain below:



Location of Pain
☐ Groin area ☐ Buttock area
☐ Down front of leg to knee
☐ Inner side of knee
☐ Outer side of knee
☐ Knee cap area ☐ All over

Knee/Hip give out or buckles:
☐ Never ☐ Often
☐ While walking ☐ While on stairs
☐ While pivoting/twisting

Grating, Grinding, Clicking:
☐ None ☐ While walking
☐ While on stairs

Locking:
☐ None ☐ Often ☐ Occasional

Swelling:
☐ None ☐ Occasional ☐ Constant
☐ Only with activity

Position of Leg:
☐ Becoming more bowlegged
☐ Becoming more knock-kneed

Walking aids:
☐ Cane ☐ Crutches
☐ Walker ☐ Wheelchair

Mobility (Limp)
☐ Limp ☐ No Limp ☐ Can't run

How far can you walk?
☐ 1 Block ☐ 1 Mile
☐ 2 Blocks ☐ 2 Miles
☐ 3 Blocks ☐ Housebound

Prior Treatment:

Knee / Hip surgery?	☐ Yes	☐ No
Knee / Hip injection?	☐ Yes	☐ No
Knee Brace?	☐ Yes	☐ No
Medication?	☐ Yes	☐ No
Physical Therapy?	☐ Yes	☐ No
Off work?	☐ Yes	☐ No