

HIP/KNEE QUESTIONNAIRE

Patient Name _____ 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

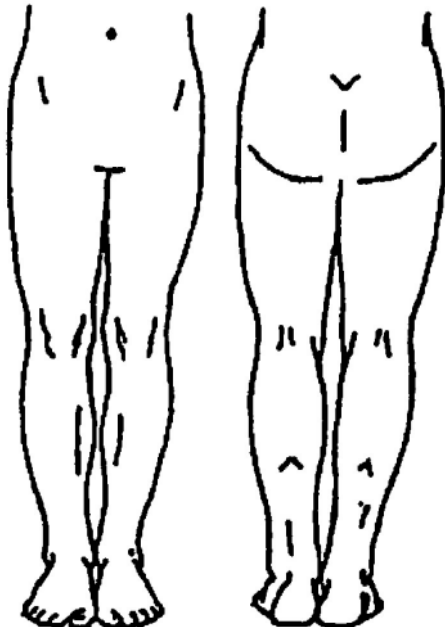
Amount of Pain:

- 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