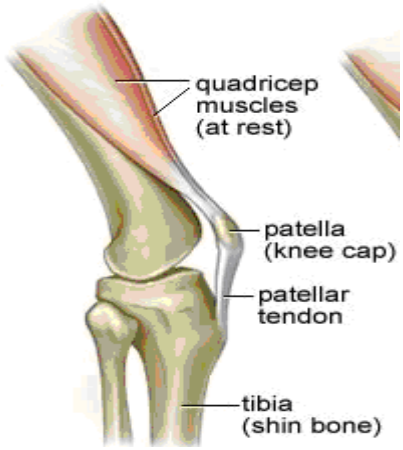
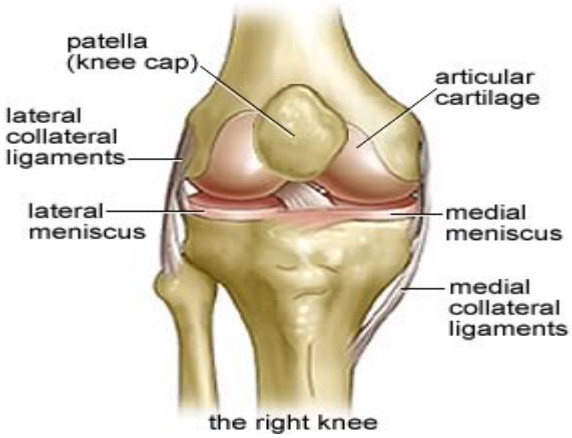
EDWIN P. SU, MD
The Hospital for Special Surgery
Knee Questionnaire

Name: _____Today's Date_____

Involved knee: R L Both

Pain: Y N **Location of pain (circle on diagram)**





Duration of pain: Months_____/Years_____

Night pain: Yes No Swelling: Yes No

Giving way: Yes No Clicking: Yes No

Locking/catching Yes No Hip/Back pain Yes No

Pain increased by: Squatting ____ Kneeling ____Sitting ____ Stairs ____ Sudden turns___

Activities which increase pain:_____

Anti-inflammatory medications helpful? Y N Not tried

Injections helpful? Y N Not tried

Physical therapy helpful? Y N Not tried

Previous knee pain/injury:

Previous surgery: Yes No When?_____

Name of operating surgeon and hospital?_____