DR. WEBER KNEE INFORMATION SHEET

Name:______________________________ DOB: _____________ Date: _____________

In order to make your evaluation and treatment more efficient, we would appreciate you completing this questionnaire as accurately as possible. Please check off all appropriate answers.

1. Is your knee problem injury related? Yes _____ No _____
2. How were you injured? Sports _____ Work _____ Motor Vehicle _____ Other _____
   Please Describe _______________
3. If you had an injury, did your knee swell? Yes _____ No _____
4. How rapidly did your knee swell? Immediately _____ Over 2 hours _____ Within 24 hours _____
5. If an injury, did your knee click _____, snap _____, or pop _____?
6. Does your knee continue to swell? Yes _____ No _____
7. Do you have pain :

Climbing Stairs	Yes _____	No _____
Kneeling/Squatting	Yes _____	No _____
Walking on level ground	Yes _____	No _____
Driving	Yes _____	No _____
Sitting Knee Bent	Yes _____	No _____
At Night	Yes _____	No _____

8. Does your knee give-way or buckle? Yes _____ No _____
9. Does your knee lock or get stuck in one position? Yes _____ No _____
10. Does your knee click _____, snap _____, or pop _____?
11. Do you take medication for your knee? Yes _____ No _____
12. If you take medication: Name of pill: _______________ Strength: _____mgs,
    How many? _______ How often? ______hrs
13. Have you had a cortisone injection to the knee? Yes _____ No _____
14. Have you had physical therapy? Yes _____ No _____
    If yes, where? ________________________________
    If yes, for how long? ______ weeks ______ months If yes, has it helped? Yes _____ No
    If yes, are you still going? Yes _____ No ____

16. Have you worn a brace for support? Yes _____ No _____
17. Have you ever had an operation on your knee? Yes _____ No _____
    If yes, what operations? ________________________________
18. Have you had:

Knee X-ray	Yes _____	No _____
Knee MRI	Yes _____	No _____
Knee CATScan	Yes _____	No _____