# KNEE PAIN QUESTIONNAIRE

***KNEE PAIN*: (If you have pain on only one side, you can skip questions related to the other side.)**

What side is your pain on?

☐Left ☐Right ☐Bilateral. If Bilateral: ☐ Equal ☐ Left greater than Right ☐ Right greater than Left

---

How long have you had knee problems?

**Left knee:**

Please specify how many days, weeks, months, or years:_____

If injured, what was the date of injury? _____

**Right knee:**

Please specify how many days, weeks, months, or years:_____

If injured, what was the date of injury? _____

---

How severe is your pain? (Circle one.) 0 is no pain and 10 is worst pain of your life.

**Left knee:**

SCALE OF PAIN: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Right knee:**

SCALE OF PAIN: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

---

Where do you feel your knee pain? (Mark all that apply or describe it yourself on the blank line provided)

**Left knee:** _____

☐No pain ☐Front of knee ☐ Inner side of the knee - medial ☐Outer side of the knee - lateral

☐ Entire knee ☐ Back of the knee ☐ Above knee cap ☐Under knee cap

**Right knee:** _____

☐No pain ☐Front of knee ☐ Inner side of the knee - medial ☐Outer side of the knee - lateral

☐ Entire knee ☐ Back of the knee ☐ Above knee cap ☐Under knee cap

---

What does the pain feel like? (Mark all that apply or describe it yourself on the blank line provided)

**Left knee:** _____

☐Dull ☐Achy ☐Sharp ☐A baseline dull and achiness with episodes of sharp pain

☐Throbbing ☐Burning ☐Stabbing ☐Crampy

**Right knee:** _____

☐Dull ☐Achy ☐Sharp ☐A baseline dull and achiness with episodes of sharp pain

☐Throbbing ☐Burning ☐Stabbing ☐Crampy

---

Does the pain radiate? Yes / No. If yes, where does it radiate to? (Mark all that apply or describe it yourself)

**Left knee:** _____

☐Knee to hip ☐To the ankle ☐Into foot ☐ Into the toes ☐Into back of knee

☐ Down outer leg ☐Down inner leg ☐Down back of leg to knee ☐Down back of leg to foot

**Right knee:** _____

☐Knee to hip ☐To the ankle ☐Into foot ☐ Into the toes ☐Into back of knee

☐ Down outer leg ☐Down inner leg ☐Down back of leg to knee ☐Down back of leg to foot

---

Do you have swelling?

**Left knee:** _____

☐None ☐ Mild ☐ Moderate ☐ Severe ☐ Intermittent ☐Initially present, but resolved

**Right knee:** _____

☐None ☐ Mild ☐ Moderate ☐ Severe ☐ Intermittent ☐Initially present, but resolved

---

Pain is aggravated by: (Mark all that apply or describe it yourself on the blank line provided)

**Left knee:** _____

☐Ascending stairs ☐Descending stairs ☐Arising from a chair ☐Kneeling or squatting ☐Going from sit-to-stand
☐Walking ☐ Exercise ☐In/out of a car ☐Bending the knee ☐Twisting ☐Pivoting ☐Sitting for long periods of time

**Right knee:** _____

☐Ascending stairs ☐Descending stairs ☐Arising from a chair ☐Kneeling or squatting ☐Going from sit-to-stand
☐Walking ☐ Exercise ☐In/out of a car ☐Bending the knee ☐Twisting ☐Pivoting ☐Sitting for long periods of time

---

Pain is relieved by: (Mark all that apply or describe it yourself on the blank line provided)

**Left knee:** _____

☐Rest ☐Sitting ☐Standing ☐Lying down ☐Stretching ☐Extending the knee
☐Pain medications ☐Topical ointments ☐Topical patches ☐Ice ☐Heat ☐Nothing

**Right knee:** _____

☐Rest ☐Sitting ☐Standing ☐Lying down ☐Stretching ☐Extending the knee
☐Pain medications ☐Topical ointments ☐Topical patches ☐Ice ☐Heat ☐Nothing

---

Associated symptoms?

**Left knee:** _____

☐None ☐ Clicking ☐ Popping ☐Locking ☐Catching

**Right knee:** _____

☐None ☐ Clicking ☐ Popping ☐Locking ☐Catching

---

How does your knee pain affect your ability to walk?

**Left knee:** _____

☐No difficulty ☐Slight ☐Mild ☐Moderate ☐Marked/serious limitations
☐Only walks around the house ☐Totally disabled, wheelchair bound

**Right knee:** _____

☐No difficulty ☐Slight ☐Mild ☐Moderate ☐Marked/serious limitations
☐Only walks around the house ☐Totally disabled, wheelchair bound

---

How far can you walk without stopping because of your knee pain?

**Left knee:** _____

☐Unlimited ☐ > 6 blocks (30 mins) ☐2-3 blocks (10-15 minutes) ☐< 1 block ☐Indoors only ☐ Bed to chair

**Right knee:** _____

☐Unlimited ☐ > 6 blocks (30 mins) ☐2-3 blocks (10-15 minutes) ☐< 1 block ☐Indoors only ☐ Bed to chair

---

Do you need support when walking?

☐ None ☐ Cane for long walks ☐ Cane full time ☐ One crutch
☐ Two canes ☐ Two crutches ☐ Walker ☐Unable to walk / wheelchair

---

What have you tried to improve your knee pain?

☐Weight loss ☐NSAIDs ☐Tramadol ☐ Tylenol ☐ Physical therapy ☐Brace ☐Ice ☐Heat
☐Cane/Walker ☐Glucosamine ☐Cortisone injections ☐Other: _____

---

If you've had an injection in the involved joint, how many have you had?

**Left knee:**

☐None ☐One ☐ Two ☐ Three ☐ Other: _____. When was the last one injection? _____

**Right knee:**

☐None ☐One ☐ Two ☐ Three ☐ Other: _____. When was the last one injection? _____

---

Do you experience knee pain at rest?

**Left knee:**

☐None ☐ Mild ☐Moderate ☐ Severe

**Right knee:**

☐None ☐ Mild ☐Moderate ☐ Severe

---

Does your knee pain interfere with sleeping? Yes / No
Have you ever had a DVT (deep vein thrombosis)? Yes / No
Have you ever had a PE (pulmonary embolism? Yes / No
Do you have any history of bleeding or clotting disorders? Yes / No
Has anyone in your immediate family had a DVT or PE? Yes / No

---

Current living arrangements:

- ☐ I live alone in a house or apartment
- ☐ I live in a house or apartment with my spouse/relatives or other(s)
- ☐ I live in a nursing home or residential health care facility
- ☐ Other: _____
- ☐ Do you have stairs in your home/apartment? Yes / No. If yes, how many? _____

---

Previous Surgery on _____? (mm/yyyy) Type of Surgery and Name of Surgeon

**Left knee:** ☐YES ☐NO _____ _____
**Right knee:** ☐YES ☐NO _____ _____
**Left hip:** ☐YES ☐NO _____ _____
**Right hip:** ☐YES ☐NO _____ _____

Previous infection _____?

**Left knee:** ☐YES ☐NO **Left hip:** ☐YES ☐NO **Other:** _____
**Right knee:** ☐YES ☐NO **Right hip:** ☐YES ☐NO

Other types of surgery? Date of Surgery (mm/yyyy)

_____ _____
_____ _____
_____ _____