DR JULIAN YU
BMed FRACS (Orth) FAOrthA
CONSULTANT ORTHOPAEDIC SURGEON
SPECIALIST HIP AND KNEE SURGEON

PATIENT KNEE HISTORY FORM

Name: ________________________________

Date of Birth: __________________________

Which Knee: ☐ **Left** ☐ **Right** ☐ **Both**

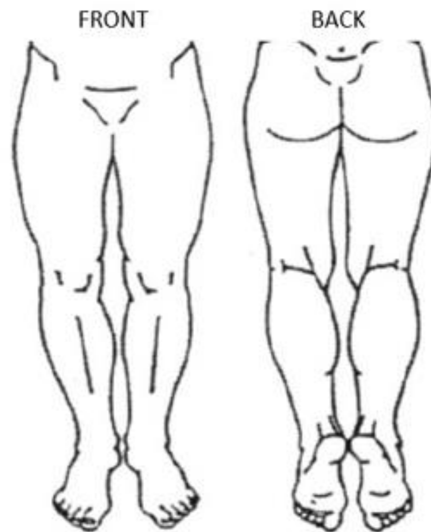
Chief Complain: ____

Problems with Your Knee: ☐ **Pain** ☐ **Stiffness** ☐ **Instability (Giving Way)** ☐ **Other** _____________________

When Did Your Problems Start: ____

How Did It Start (Ie. Fall/Injury/Sport/Work): __________________________________

Where Do You Have Pain About the Knee?
(Please Indicate on Diagram)



Does Any Position / Activity Make the Pain Better / Worse: ___________________________

Do You Have Knee Problems at Night: ____

Turning/Twisting in Bed: ☐ **Yes** ☐ **No** **Sitting to Standing:** ☐ **Yes** ☐ **No**

Do You Have Pain With Stairs: ________________________ **If So, Worse Up or Down:** ________________________

Swelling: ☐ **Yes** ☐ **No** **Giving Way:** ☐ **Yes** ☐ **No**

What Treatment(s) Have You Had So Far: ____

How Far/Long Can You Walk Before the Pain Stops You (Ie. 300m/30min): ______________________

Previous Problems or Surgery With Your Knee: ____________________________________

What Activities Do You Want To Return To: _______________________________________

Medical Conditions & Previous Surgeries: _______________________________________

____

Do You Have a History of Blood Clots, Clotting Disorders or Bleeding Disorders: ____________________

Medications / Allergies: ____

____