

**Renaissance Orthopaedics and**

**The Bone and Joint Center**

**at Magee-Womens Hospital of UPMC**

300 Halket Street, Suite 1601

Pittsburgh, PA 15213

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**KNEE EVALUATION**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**REFERRED BY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_**AGE:** \_\_\_\_\_\_\_\_ **HEIGHT:** \_\_\_\_\_\_\_\_ **WEIGHT:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Which knee are you going to be seen for?**  Left      ⁮Right     or       Both

**If both, would you describe the pain as:** Left worse than right? or Right worse than left?

**Where is your pain located?**Left knee:      ⁮Front      ⁮ Back      ⁮ Above     ⁮ Below

                                                   Right knee:   ⁮ Front       ⁮Back      ⁮Above     Below

**How would you describe the pain you usually have in your knee(s)?**

None                 Slight                  Mild                  Moderate                 Severe

**How long have you had pain in your knee(s)?**

\_\_\_\_\_\_\_\_\_\_Weeks \_\_\_\_\_\_\_\_\_\_\_Months \_\_\_\_\_\_\_\_\_\_\_\_Years

**How long are you able to walk before the pain in your knee(s) becomes severe?**

a. No pain for 30 minutes or more d. Around the house only

b.16 to 30 minutes e. Not at all

c. 5 to 15 minutes

**Over the last two weeks, how often have you had little interest or pleasure in doing things?**

Not at all Several Days More than half of the time Nearly every day

**Over the last two weeks, how often have you felt down, depressed or hopeless?**

Not at all Several Days More than half of the time Nearly every day

**Have you been limping because of your knee(s)?**

Never Sometimes         Often          Most of the time        All of the time

**Could you walk up/down a flight of stairs?**

Easily      Little Difficulty     Moderate Difficulty    Extreme Difficulty    Impossible

**Does your knee lock?** Yes     No **Does your knee give out?** Yes     No

**How long can you comfortably sit?**15 minutes    30 minutes     ⁮1 hour      ⁮ No limit

**After a meal/sitting for time how painful has it been for you to stand up from a chair?**

No Pain      Slight Pain        Moderate Pain      Very Painful    Unbearable

**How much has pain from your knee(s) interfered with your usual work (including housework)?**

Not at all A Little Bit Moderately Greatly                 Totally

**Do you use a cane, crutches, or a walker?**Always    Sometimes   Rarely      ⁮ Never

**Are you experiencing any numbness in your feet?**     ⁮ Yes       ⁮ No

**Have you had any tests done on your knee(s)?**⁮

X-ray     ⁮MRI     ⁮ CT Scan     ⁮ Bone Scan

**Have you ever had any therapy for your knee(s)?**     ⁮ Yes       ⁮ No

If yes, which knee?      ⁮ Left       ⁮ Right      ⁮ Both

**Have you had any fractures to your knee(s)?**      ⁮ Yes       ⁮ No

If yes, which knee?     ⁮ Left       ⁮ Right      ⁮ Both

**Have you ever had a blood clot?**⁮ Yes       ⁮    No

**Has anyone in your immediate family ever had a blood clot?**⁮ Yes       ⁮    No

**Have you ever had any injections?**⁮ Yes       ⁮ No

If yes, which knee?   ⁮ Left       ⁮ Right      ⁮ Both   When was your last injection? \_\_\_\_\_\_\_\_\_

**Medication Injected:** ⁮ Cortisone      ⁮Synvisc     ⁮ Hyalgan     ⁮ Supartz      ⁮ Euflexxa

**Have you had any surgery on your knees?**⁮ Yes       ⁮No

If yes, which knee?Left       Right     Both

**Are you considering surgery?**⁮ Yes       ⁮ No

**If yes, how soon?**⁮ Immediately     ⁮ 3 months     ⁮ 6 months     ⁮ more than 6 months

**Do you take pain medicine?**   Yes / No     **Does it Help?** Yes / No

**What are you taking for pain?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you tried anything else to help with your pain?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any special comments or questions for our provider(s)?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_