**BECKER ORTHOPEDICS**

**Advanced skills and experience for the results you deserve**

# PATIENT INFORMATION SHEET

Knee

Right Left

Name: _____

Date:_____

**Please give a brief description of your symptoms/problems. (Where and how does it hurt)**

_____

_____

_____

**When did this start?**
(approximate date or number of days, weeks, months, years)

_____

**History of Injury?**

_____

**How does your knee hurt? (Circle which one applies)**

**Inside Outside Front Back Above the knee Below the knee**

**Have you had any surgery on your knee?**

**Yes No When?_____**

**Type of operation, if known_____**

**Have you had any of these examinations done to your Knee?**

**X-rays? Where?_____When?_____**
**Arthrogram? Where?_____When?_____**
**CT? Where?_____When?_____**
**Ultrasound? Where?_____When?_____**
**MRI? Where?_____When?_____**