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Knee Form

Please complete and bring with you to your appointment.

Right Left

Symptoms:

Pain with activity Y N (describe): _____

Pain at rest Y N (describe): _____

Pain at night Y N (describe): _____

Locking Y N (describe): _____

Instability Y N (describe): _____

Limited motion Y N (describe): _____

Swelling Y N (describe): _____

Limited strength Y N (describe): _____

Decreased strength Y N (describe): _____

Treatment:

Oral medications? Y N (describe): _____

Oral medications helpful? Y N

Physical Therapy? Y N (describe): _____

Physical Therapy helpful? Y N

Braces Y N (describe): _____

Braces helpful? Y N

Injections Y N (describe): _____

Injections helpful? Y N

Similar problem on the other side? Y N (describe): _____

Patient Name: _____ Date: _____

MM/DD/YYYY