

Edwin M. Tingstad, M.D.

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