MINNEAPOLIS
ORTHOPAEDICS
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?**_____