Name:
Chart:
Age:
Date:

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DR. CIMINIELLO
KNEE MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Date: _____

Height: _____" Weight: _____ lbs.

Orthopedic History: _____ Reason for Visit: _____

Is this problem a result of: ❑ MVA ❑ Liability ❑ Work Related ❑ Trauma

Date of Injury: _____ Description of Injury: _____

Side: ❑ Right ❑ Left Dominant: ❑ Right-Handed ❑ Left-Handed

History of Present Injury or Complaint: _____

How long have you had knee pain? _____
Did you have an injury? (explain) _____
Does your knee feel unstable (feeling like it may give way on you)? ❑ Yes ❑ No
Does your knee lock? ❑ Yes ❑ No
Does your knee hurt when you go up and down stairs? ❑ Yes ❑ No
Does your knee hurt when you squat down? ❑ Yes ❑ No
Does your knee swell ? ❑ Yes ❑ No
What sports or activities do you participate in ? _____
Are you taking any medications for your knee? _____

DO YOU HAVE ALLERGIES, SENSITIVITIES OR HAVE YOU AN ADVERSE REACTION TO MEDICATIONS OR LATEX? ❑ Yes ❑ No
Please List: _____

CURRENT MEDICATIONS: _____

OTHER MEDICAL PROBLEMS: _____

HISTORY OF OPERATIONS: ❑ Yes ❑ No
Type: _____