PANDA PHYSICAL MEDICINE,LLC

OA Patient Questionnaire

1. Have you experienced any knee pain recently? **Yes or No**
2. If so, are you having pain in the left knee **Yes or No** or right knee **Yes or No**?
3. Do you experience pain in both knees at times? **Yes or No**
4. Have you had any x-rays or mris done on your knees? **Yes or No** If so, where _____ and when_____.
5. Does your knee pain a result of an accident or injury that you incurred? **Yes or No**
6. Have you ever had any knee surgeries? **Yes or No**. If yes, when was your last surgery_____.
7. Have you ever been diagnosed with arthritis of the knees or any type of osteoarthritis**? Yes or No**.
8. Have you ever had any knee injections**? Yes or No**- If yes, when was your last injection and by whom_____.
9. Does your current knee pain affect your quality of life? For example, does it prevent you from attending certain events or engaging in any physical activity? **YES or NO**. Please explain_____
10. Have you had any recent falls? **Yes or No** – When _____
11. How many falls have you experienced within the last 6 months? _____
12. Are you experiencing any numbness, tingling, or burning sensation with the knee pain? **Y months or No.**
    Explain_____.
13. Do you currently use a cane or other device to help you walk? **Yes or No** If so, what do you use_____.
14. Have you attempted to lose weight because of the pain**? Yes or No**. If you have lost weight recently, how much have you lost and has it helped to improve your pain symptoms**? Yes or No**_____.
15. Have you ever experienced any buckling of the knees upon walking? **Yes or No**
16. Does your current pain cause you to be depressed or experience suicidal thoughts? **Yes or No**
17. Does your current pain interfere with your ability to sleep good at night? **Yes or No**
18. Have you attempted to use any kind of hot or cold therapies to help with the pain? **Yes or No** If so, did any of this work- Explain_____
19. Are you currently using opioids (pain medication) to assist with the pain? **Yes or No**- If yes, how long have you been taking the medications_____. If you don't use prescribed pain medication, what kind of medication do you use_____
20. Do you experience any pain relief from the oral medications that you take? **Yes or No**