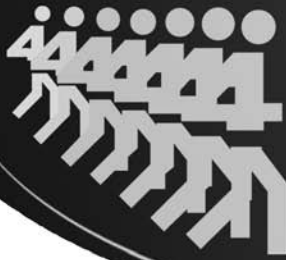


GEORGES A. BAHRI, M.D.
FADY A. BAHRI, M.D.
FARID HAKIM, M.D.
KAMAL BOHSALI, M.D.



BAHRI ORTHOPEDICS
& SPORTS MEDICINE
CLINIC, P.A.

Knee Chart History

Created 05/12/2009

Name: _____ Date: _____ Age: _____

Knee Problem: _____ Right Left

Date of Onset: _____ Injury: Yes No (Describe Injury) _____

How Did Pain or Problem Begin? _____

Symptoms

Is your knee problem	<input type="checkbox"/> intermittent	<input type="checkbox"/> constant
Soreness/Aching	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Popping, clicking, grinding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of motion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stiffness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tenderness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty going up and down stairs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Locking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Giving way	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does knee pain wake you or keep you awake	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Past knee problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you in good general health	<input type="checkbox"/> Yes	<input type="checkbox"/> No