Knee Injection Questionnaire

Please complete all information below.

ORTHOWASHINGTON

Patient Information

First Name: _____ MI: _____ Last: _____

Preferred Name: _____ Gender: _____

Date of Birth: _____ Age: _____

Doctor's Name: _____ Appointment Date: _____

Knee Information

☐ Left Knee ☐ Right Knee ☐ Both Knees

Self-Evaluation

1. Since you last visit, how are you feeling? ☐ Better ☐ Worse ☐ Same ☐ Too early to tell

2. On a scale of 0 to 10 (10 is worst), what is the severity of your pain? (circle one):

   0 1 2 3 4 5 6 7 8 9 10

3. On a scale of 0 to 100%, **how much better** are you than the last visit? (0% = no better):

   _____ %

4. Are you having or have you had any side effects from HA injections? ☐ Yes ☐ No

   If "Yes" please explain: _____

   _____

Patient Signature: _____ Date: _____

MD/PA-C Signature: _____ Date: _____

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