

# Knee Injection Questionnaire

Please complete all information below.



## 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: