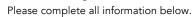
Knee Injection Questionnaire





Patient Information				
First Name:	N	11:	Last:	
Preferred Name:	Gende	er:		
Date of Birth:	Ag	e:		
Doctor's Name:	Д	ppointment [Date:	
Knee Information				
Left K	nee Righ	t 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	0%, how much better are	e you than the	e last visit? (0% = no b	etter):
4. Are you having or have you had any side effects from HA injections?				
If "Yes" please explain:				
Patient Signature:			Date:	
MD/PA-C Signature:			Date:	