

## KNEE/LEG/ANKLE/FOOT SCREENING QUESTIONNAIRE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Have you recently experienced a trauma, such as a vehicle accident, a fall from a height, or a sports injury?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you recently had a fever?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you recently taken antibiotics or other medicines for an infection?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had a recent surgery?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had a recent injection to one or more of your joints?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you recently had a cut, scrape, or open wound?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have diabetes?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you been diagnosed as having an immunosuppressive disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have a history of heart trouble?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have a history of cancer?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you recently taken a long car ride, bus trip, or plane flight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you recently been bedridden for any reason?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you recently begun a vigorous physical training program?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you have groin, hip, thigh or calf aching or pain that increases with physical activity, such as walking or running? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you recently sustained a blow to your shin or any other trauma to either of your legs?                             | <input type="checkbox"/> | <input type="checkbox"/> |