# 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?** | ☐ | ☐ |
| **2. Have you recently had a fever?** | ☐ | ☐ |
| **3. Have you recently taken antibiotics or other medicines for an infection?** | ☐ | ☐ |
| **4. Have you had a recent surgery?** | ☐ | ☐ |
| **5. Have you had a recent injection to one or more of your joints?** | ☐ | ☐ |
| **6. Have you recently had a cut, scrape, or open wound?** | ☐ | ☐ |
| **7. Do you have diabetes?** | ☐ | ☐ |
| **8. Have you been diagnosed as having an immunosuppressive disorder?** | ☐ | ☐ |
| **9. Do you have a history of heart trouble?** | ☐ | ☐ |
| **10. Do you have a history of cancer?** | ☐ | ☐ |
| **11. Have you recently taken a long car ride, bus trip, or plane flight?** | ☐ | ☐ |
| **12. Have you recently been bedridden for any reason?** | ☐ | ☐ |
| **13. Have you recently begun a vigorous physical training program?** | ☐ | ☐ |
| **14. Do you have groin, hip, thigh or calf aching or pain that increases with physical activity, such as walking or running?** | ☐ | ☐ |
| **15. Have you recently sustained a blow to your shin or any other trauma to either of your legs?** | ☐ | ☐ |