

Please complete the below information and send to CMI via email to: info@canmagnetic.com.
Once CMI receives this form, one of our staff will contact you promptly.

Patient Name:
First Name Last Name

Email Address:

Treatment required for affected knee: Left Right

Symptoms

Do you have swelling in your knee? Yes No

Do you feel grinding, hear clicking or any other type of noise when your knee moves? Yes No

Does your knee catch or hang up when moving? Yes No

Can you straighten your knee fully? Yes No

Can you bend your knee fully? Yes No

Diagnosis

Have you been diagnosed with Osteoarthritis? Yes No

Has your health care provider assessed the grade of Osteoarthritis? Yes No

If yes, what grade of Osteoarthritis are you?

Imaging

Do you have access/availability of imaging of the affected knee? Yes No

Date of last affected knee imaging:

Do you have a radiologist report with a grade of Osteoarthritis that you can provide us? Yes No

Previous Surgeries/Treatments in the Affected Knee

Have you attended any of the following for treatment of the affect knee?

Physiotherapy Acupuncture Massage Therapy Osteoplasty Pain injections Topical Treatments

Other Please Describe:

Have you had a knee arthroscopy in the last 6 months? Yes No

If yes, which knee? Left Right

Have you previously received knee surgery (alloplasty) or have any foreign material in your affected knee? Yes No

If yes, type of surgery:

Date of surgery:

Have you received treatment with a different non-absorbable injectate or implant in your affected knee? Yes No

If yes, name of product:

Date of surgery:

Have you received a degradable intra-articular injectable (hyaluronic acid) in your affected knee? Yes No

If yes, name of injectate:

Date of Injection:

Current Medical Conditions

Drug Allergies

Known allergies or sensitivity to polyacrylamide hydrogel? Yes No

Known allergies or sensitivity to antibiotics? Yes No

If yes, which antibiotic(s)?

Please list any other health problems (other than pain problems) that you currently have:

Problem #1:

Treatment:

Year of onset:

Problem #2:

Treatment:

Year of onset:

Problem #3:

Treatment:

Year of onset:

Additional current medical problems:

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Past Medical History

Please list any other serious health problems or major illnesses you have had in the past:

Problem or Illness #1:

Year of onset:

Problem or Illness #2:

Year of onset:

Problem or Illness #3:

Year of onset:

Do you have a history of kidney disease? Yes No

Are you on blood thinners (this includes daily Aspirin)? Yes No

If yes, what is the name of the medication and dose:

Past Surgical History

Please list any surgery you have had that was NOT related to your pain:

Type of Surgery #1:

Date:

Type of Surgery #2:

Date:

Type of Surgery #3:

Date:

Are you scheduled for surgery or any other medical procedures for your pain? Yes No

If yes, what surgery/procedure?

Date of surgery/procedure?

Social History

How many days in a typical week are you active more than 20 minutes? Yes No

Occupation Full Time Part Time

Are you presently concerned about financial problems or major debts? Yes No

In the past, have you received any financial benefits or compensation for your pain or injury? Yes No

Are you presently involved in legal action that is related to your pain or injury? Yes No

Please save your completed forms to your device and email to info@canmagnetic.com