DT535

Atlantic Health System

PATIENT ID HERE

PRE-PROCEDURAL ASSESSMENT TOTAL JOINT REPLACEMENT

(Please Print Legibly)

Name: _____ **Birth Date:** _____

Location of pain: ☐ Hip ☐ Knee ☐ Right ☐ Left ☐ Both

Severity of Pain: (Scale 0-10) ☐ None (0) ☐ Mild (1-3) ☐ Moderate (4-6) ☐ Severe (7-10)

Nature of Pain: *Night pain?* ☐ Yes ☐ No
Pain? ☐ at Rest ☐ After walking ☐ With weight-bearing ☐ After exercise ☐ After climbing stairs

Duration of pain symptoms: ☐ 1-3 months ☐ 4-6 months ☐ one year ☐ more than a year

Knee swelling? ☐ Yes ☐ No

Joint stiffness? ☐ Yes ☐ No
Is range of motion restricted? ☐ Yes ☐ No

Activities of daily living (ADL):
Difficulty putting on stockings, socks or shoes? ☐ Yes ☐ No
Able to squat or kneel? ☐ Yes ☐ No
Stand from a seated position? ☐ Without using arms ☐ Using arms ☐ With great difficulty
How far can you walk comfortably? ☐ More than 10 blocks ☐ 5-10 blocks ☐ 1-4 blocks
☐ Supermarket leaning on the cart ☐ Unable
Do you need to use a walking aid? ☐ cane ☐ walker ☐ crutches ☐ no aid
Difficulty climbing stairs? ☐ go up and down normally ☐ need to use the railing
☐ go one step at a time ☐ unable to climb stairs
Do you have difficulty with bathing or personal hygiene? ☐ Yes ☐ No

Physical therapy: *Was physical therapy prescribed?* ☐ Yes ☐ No
If Yes, for how long? ☐ 3-6 weeks ☐ 7-12 weeks ☐ more than 12 weeks

If *no, or if Physical Therapy lasted less than 12 weeks, are/were you unable to participate in Physical Therapy due to severe joint pain?* ☐ Yes ☐ No

Did you use wraps, supports or braces to support your Knees? ☐ Yes ☐ No
Were they effective? ☐ Yes ☐ No ☐ Help somewhat

Flexibility and Strengthening Exercise: *Were you told to exercise?* ☐ Yes ☐ No
If Yes, did it help? ☐ Yes ☐ No

Medications: *Do you take medication for your condition?* ☐ Yes ☐ No
If Yes, how frequently? ☐ occasionally ☐ at bedtime ☐ regularly
Type of medication? ☐ Over the counter medications (aspirin, acetaminophen (Tylenol, Advil, Aleve)
☐ Prescription medications (NSAIDs, steroids, narcotics)*
☐ Steroid (cortisone) injections or other joints injections (Synvisc, Orthovisc, Hyalgan, etc.)
For how long have you taken medications for this condition? ☐ less than 3 months ☐ 3 months or more

Weight reduction: *Were you told to lose weight?* ☐ Yes ☐ No
If Yes, were you able to lose weight? ☐ Yes ☐ No
If Yes, how much did you lose? ☐ less than 10 lbs ☐ 10-20 lbs ☐ more than 20 lbs

Activity Restrictions: *Were you told to decrease activity or exercise?* ☐ Yes ☐ No
If Yes, what activity has been restricted? ☐ Running ☐ Walking ☐ Lifting ☐ Bicycling
☐ Tennis ☐ Other _____

Patient Signature: _____ Date: _____

I have reviewed and agree with the above

Physician Signature: _____ Date: _____ Time: _____

*NSAIDS (Non-Steroidal Anti-inflammatory Medications) such as Motrin, Ibuprofen, Celebrex, Naprosyn, etc.; steroids (cortisone preparations like Prednisone, Medrol, etc.), narcotics (Codeine, Vicodin, Percocet).

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PRE-PROCEDURAL ASSESSMENT TOTAL JOINT REPLACEMENT

Name: _____ **Birth Date:** _____

Physical Findings *(All **bold** findings must be present)*

Knee ☐ Left ☐ Right ☐ Both

☐ **Pain and tenderness of the knee overlying:** ☐ medial joint line (MJL) ☐ Lateral Joint line (LJL) ☐ Both (medial and lateral) ☐ patella ☐ diffuse

☐ **Pain worse with passive motion** ☐ Pain increased with active motion

☐ **Range of Motion limited:** ☐ 5-10° ☐ 11-20° ☐ >20°

☐ **Joint crepitus present**

☐ **Joint effusion/swelling**: ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+

X-ray Findings *(Two or more must be present)*

☐ **Subchondral sclerosis**

☐ **Subchondral cysts**

☐ **Periarticular osteophytes**

☐ **Joint subluxation**

☐ **Joint space narrowing:**

☐ medial ☐ lateral ☐ patella-femoral ☐ tri-compartmental

Hip ☐ Left ☐ Right ☐ Both

☒ **Pain/tenderness localized in the hip region:** ☒ groin ☐ trochanteric area ☐ buttock

☒ **Pain upon weight bearing** ☒ Pain with motion of the hip

☒ **Pain with passive range of motion** (PROM)

☒ **Limited range of motion:**

☒ Flexion restricted (N=135°)	☐ 5-10°	☐ 11-20°	☒ >20°
☒ Abduction restricted (N=45°)	☒ 5-10°	☐ 11-20°	☐ >20°
☒ Internal rotation (N=35°)	☒ 5-10°	☐ 11-20°	☐ >20°
☒ External rotation (N=45°)	☒ 5-10°	☐ 11-20°	☐ >20°
☒ Adduction restricted (N=25°)	☒ 5-10°	☐ >10°	
☐ Extension restricted (N=15°)	☐ 5-10°	☐ >10°	

☒ **Antalgic gait pattern**

X-ray Findings *(Two or more must be present)*

☒ **Subchondral sclerosis**

☒ **Subchondral cysts**

☒ **Periarticular osteophytes**

☐ **Joint subluxation**

☒ **Joint space narrowing:**

Supplemental question for Medicare patients only

Has the patient used narcotics chronically (greater than or equal to 90 days)

☐ Yes ☐ No

Physician Signature: _____ Date: _____ Time: _____

DT527

Atlantic
Health System

HOOS, JR.[1] HIP SURVEY

PATIENT NAME:		PATIENT ID:
DATE OF SURGERY:	**INDICATE IF THIS IS:** ☐ PRE-OP ☐ POST-OP	**SIDE:** ☐ RIGHT ☐ LEFT ☐ BOTH

INSTRUCTIONS: This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities. Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Pain

What amount of hip pain have you experienced the last week during the following activities?

	None	Mild	Moderate	Severe	Extreme
1. Going up or down stairs	☐	☐	☐	☐	☐
2. Walking on an uneven surface	☐	☐	☐	☐	☐

Function, daily living

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

	None	Mild	Moderate	Severe	Extreme
3. Rising from sitting	☐	☐	☐	☐	☐
4. Bending to floor/pick up an object	☐	☐	☐	☐	☐
5. Lying in bed (turning over, maintaining hip position)	☐	☐	☐	☐	☐
6. Sitting	☐	☐	☐	☐	☐

Patient Signature: _____ Date: _____

[1] Hip dysfunction and Osteoarthritis Outcomes Score for Joint Replacement (HOOS, JR.), English version 1.0
https://www.hss.edu/files/HOOS-JR-2015.pdf

Atlantic
Health System

PATIENT ID

RISK ASSESSMENT AND PREDICTION TOOL (RAPT)

To be completed by the patients undergoing elective Hip or Knee replacement surgery prior to discussion with your orthopedic surgeon or attending Pre-admission Clinic

Patient Name: _____ DOB: _____

Surgeon: John Dundon, MD

Insurance: _____ Date of Surgery: _____

	Check only 1 box for each question	Score
1. What is your age group?	☐ 50-65 years ☐ 66-75 years ☐ greater than 75 years	=2 =1 =0
2. Gender?	☐ Male ☐ Female	=2 =1
3. How far on average can you walk? (a block is 200 meters/ 600 feet)	☐ Two blocks or more (+/-rest) ☐ 1-2 blocks (+/-rest) ☐ Housebound (most of time)	=2 =1 =0
4. Which gait aid do you use? (more often than not)	☐ None ☐ Single-point cane ☐ Crutches/walker	=2 =1 =0
5. Do you use community supports? (home help, meals on wheels, Visiting nurse)	☐ None or one per week ☐ Two or more per week	=1 =0
6. Will you live with someone who can care for you after your operation?	☐ Yes ☐ No	=3 =0

Patient Signature: _____ Date: _____

Atlantic
Health System

DT527

PATIENT ID
HERE

PROMIS*- GLOBAL HEALTH

*Patient Reported Outcomes Measurement Information System

PATIENT NAME:		DATE OF BIRTH
PATIENT ID:	DATE OF SURGERY	**INDICATE IF THIS IS:** ☐ PRE-OP ☐ POST-OP
JOINT: ☐ HIP ☐ KNEE	**SIDE:** ☐ RIGHT ☐ LEFT ☐ BOTH	DATE OF SURVEY:

Please respond to each item by marking one box per row.

		Excellent	Very good	Good	Fair	Poor
Global01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global02	In general, would you say your quality of life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global03	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global04	In general, how would you rate your mental health, including your mood you and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1.
Global09	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1.

		Completely	Mostly	Moderately	A little	Not at all
Global06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1.

Atlantic
Health System

PATIENT ID
HERE

PROMIS*- GLOBAL HEALTH

*Patient Reported Outcomes Measurement Information System

PATIENT NAME:	DATE OF BIRTH:

In the past 7 days…

Global10	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	Never ☐ 5	Rarely ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1	
Global08	How would you rate your fatigue on average?	None ☐	Mild ☐	Moderate ☐	Severe ☐	Very Severe ☐	
Global07	How would you rate your pain on average?	☐ 0 No pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Worst imaginable pain

Pre-operative supplemental Questions - to be answered BEFORE SURGERY only

P1. What amount of pain have you experienced in the last week in your OTHER knee/hip

None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

P2. My BACK PAIN at the moment is:

None ☐ Very Mild ☐ Moderate ☐ Fairly Severe ☐ Very Severe ☐ Worst Imaginable ☐

P3. How comfortable are you filling out medical forms by yourself?

Extremely ☐ Quite a bit ☐ Somewhat ☐ A little bit ☐ Not at all ☐

Patient Signature: _____ Date: _____