



DT535

Atlantic Health System

PRE-PROCEDURAL ASSESSMENT TOTAL JOINT REPLACEMENT

PATIENT ID HERE

(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
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
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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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: \_\_\_\_\_



**KOOS, JR.<sup>1</sup> KNEE SURVEY**

PATIENT NAME:		PATIENT ID:		
DATE OF SURGERY:	INDICATE IF THIS IS:	<input type="checkbox"/> PRE-OP	<input type="checkbox"/> POST-OP	SIDE: <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH

**INSTRUCTIONS:** This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee 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.

**Stiffness**

The following question concerns the amount of joint stiffness you have experienced during the last week in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

- |   | None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. How severe is your knee stiffness after first waking in the morning? | <input type="checkbox"/> |

**Pain**

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

- |                                   | None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 2. Twisting/pivoting on your knee | <input type="checkbox"/> |
| 3. Straightening knee fully       | <input type="checkbox"/> |
| 4. Going up or down stairs        | <input type="checkbox"/> |
| 5. Standing upright               | <input type="checkbox"/> |

**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 knee.

- |                                       | None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
|---------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 6. Rising from sitting                | <input type="checkbox"/> |
| 7. Bending to floor/pick up an object | <input type="checkbox"/> |

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup>Knee Injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS, JR.), English version 1.0  
<https://www.hss.edu/files/KOOS-JR-2015.pdf>  
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**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: \_\_\_\_\_

Insurance: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PROMIS\*- GLOBAL HEALTH**

\*Patient Reported Outcomes Measurement Information System

PATIENT NAME:		DATE OF BIRTH	
PATIENT ID:		DATE OF SURGERY	INDICATE IF THIS IS: <input type="checkbox"/> PRE-OP <input type="checkbox"/> POST-OP
JOINT: <input type="checkbox"/> HIP <input type="checkbox"/> KNEE	SIDE: <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH	DATE OF SURVEY:	

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

		<u>Excellent</u>	<u>Very good</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
Global01	In general, would you say your health is: .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Global02	In general, would you say your quality of life is: .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Global03	In general, how would you rate your physical health? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Global04	In general, how would you rate your mental health, including your mood you and your ability to think? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 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.) .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1.
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? .....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1.

Completely Mostly Moderately A little Not at all



**PROMIS\*- GLOBAL HEALTH**

\*Patient Reported Outcomes Measurement Information System

PATIENT NAME:	DATE OF BIRTH:
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**In the past 7 days...**

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

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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

<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Extreme</u>
<input type="checkbox"/>				

**P2.** My BACK PAIN at the moment is:

<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Fairly Severe</u>	<u>Very Severe</u>	<u>Worst Imaginable</u>
<input type="checkbox"/>					

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

<u>Extremely</u>	<u>Quite a bit</u>	<u>Somewhat</u>	<u>A little bit</u>	<u>Not at all</u>
<input type="checkbox"/>				

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_