New Patient Questionnaire – Knee

Adult Reconstruction & Joint Replacement

Name:	DOB:	Today's Date:

What is the reason for your visit? _____

_____

Laterality:	Left	Right	Both

Please describe your symptoms: (Mark all that apply)			
Throbbing pain	Radiating pain	Dull pain	Sharp pain
Catching/Locking	Swelling	Stiffness	Instability
Other:			

Where is the pain located in your hip? (Mark all that apply)				
Front	Back	Inside	Outside	Other:

Current Pain Level: (no pain 0 – 10 highest)

While Walking

0	1	2	3	4	5	6	7	8	9	10

While Negotiating Stairs

0	1	2	3	4	5	6	7	8	9	10

At Rest (sitting, lying down, sleeping)

0	1	2	3	4	5	6	7	8	9	10

When did this condition start (approximate date)? _____

How did start?			
Awakened from sleep	Gradual	Progressive	Sudden
Unable to tell	Injury (describe):		
Other (describe):			

What makes it better?			
Bending joint	Ice	Light activity	Nothing
Rest	Sitting down	Sleeping	Stretching
Yoga	Other (describe):		

What makes it worse?			
Bending	Exercise	Inactivity	Kneeling
Lifting	Sitting	Sleep	Squatting
Stairs	Standing	Straightening	Stretching
Walking	Other (describe):		

Have you EVER tried any prior conservative treatment?	Yes	No	Date Started	Location/Results	Effective?
Activity modification / Lifestyle change					Yes No
Acupuncture or holistic remedies					Yes No
Anti-inflammatory medications					Yes No
Brace					Yes No
Dietary supplements					Yes No
Exercise program					Yes No
Injections					Yes No
Narcotics					Yes No
Physical therapy					Yes No
Surgery					Yes No
Walking aids (eg. Cane, Crutches, Walker)					Yes No
Weight loss					Yes No

Have you EVER had previous imaging?	Yes	No	If yes, when?
X-ray			
CT Scan			
MRI			
EMG			
Ultrasound			

Medications: Please list the medications that you CURRENTLY take			
Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Allergies: Please include any known allergies	
Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Are you allergic to iodine? Yes No

Are you allergic to latex? Yes No

Are you allergic to metal, jewelry, or nickel? Yes No

Name: _____

Knee Society Functional Assessment

How much pain do you have when walking?

None	Mild	Stairs only	Walking and stairs	Moderate occasional	Moderate continual	Severe

What distance are you able to walk?

Unlimited	> 10 blocks	5-10 blocks	< 5 blocks	House-bound	Unable

How do you climb stairs?

Normal up and down	Normal up; down with rail	Up and down with rail	Up with rail; unable down
Unable			

What type of support do you use for walking?

None	Cane	2 canes	Crutches/Walker

Are you able to use public transportation?

Able	Unable

Do you find this situation to be:

Acceptable	Unacceptable

KOOS, JR. Knee Survey

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 marking 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.

Which Knee:

Left	Right	Both

Stiffness: Amount of joint stiffness you have experienced the last week in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?

None	Mild	Moderate	Severe	Extreme

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

2. Twisting/pivoting on your knee:

None	Mild	Moderate	Severe	Extreme

3. Straightening knee fully:

None	Mild	Moderate	Severe	Extreme

4. Going up or down stairs:

None	Mild	Moderate	Severe	Extreme

5. Standing upright:

None	Mild	Moderate	Severe	Extreme

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.

6. Rising from sitting:

None	Mild	Moderate	Severe	Extreme

7. Bending to floor/pick up an object:

None	Mild	Moderate	Severe	Extreme

Name: _____

Medical History			
Please select any past or current medical conditions below:			
Anxiety	Depression	Kidney disorder	Pulmonary embolus
Arrhythmia (Irregular heartbeat)	Diabetes	Low acting thyroid	Reflux
Asthma	Heart attack	Open wounds/Ulcers	Rheumatoid arthritis
Bleeding problems	Heart failure (CHF)	Osteoarthritis	Seizures
Blood clots (DVT-PE)	High blood pressure	Osteoporosis	Stomach ulcers
Cancer	High cholesterol	Peripheral vascular disease	Stroke
Coronary artery disease	Infection	Pneumonia	Other:

Surgical and Hospitalization History	
Previous operation/Hospitalization	Occurrence date (approx.)
1.	
2.	
3.	
4.	
5.	

Have you ever had a problem with anesthesia? Yes No Problem: _____

Have you ever had complications from prior surgery? Yes No Problem: _____

Family History: What medical problems run in your direct family?		
Family Member	Problem	Alive/Deceased
Father		
Mother		
Brother		
Sister		
Grandfather		
Grandmother		

Name: _____

Social History

Are you a tobacco user? Yes No

If yes, what? _____ How much? _____

Do you consume alcohol? Yes No

If yes, what kind? _____ Drinks per week? _____

Recreational drug use? Yes No

If yes, what drug? _____ How much and how often? _____

List any recreational activities / sports that you enjoy: _____

What do you do for a living? _____

With whom do you live? _____

Screening Questions / Coordination of Care

Are you currently on any blood thinners? Yes No

Have you ever had a MRSA Infection? Yes No

Do you have any of the following medical devices? (Mark all that apply)

Pain Pump	Neurostimulator	Pacemaker and/or Defibrillator	Shunt for hydrocephalus

Do you have diabetes? Yes No

If yes, do you have an insulin pump? Yes No

Have you been taking opioids for 6 months or more (e.g. codeine, percocet, morphine, Vicodin, etc.)? Yes No

Immunizations and Falls Screening

Have you received the pneumonia vaccine? Yes No

If yes, date? _____ If not, why? _____

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? Yes No

If yes, date? _____

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? Yes No

If yes, do you have vision problems that may have contributed to your fall? Yes No

Name: _____

Review of Systems

Are you currently having, or have you had any of these problems in the past year? (Select all that apply)

Constitutional	Hematologic	Respiratory	Skin
Chills	Easy bruising/bleeding	Increased sputum	Sores/ulcers
Fever	Blood clots in legs	Cough	Itching
Sleep difficulty	Blood clots in lungs	Difficulty breathing	Dryness
Fatigue		Wheezing	Hives
Night sweats		Excessive snoring	Rash
Weight Change			Mole changes
None	None	None	None

ENT	Cardiovascular	Endocrine	Musculoskeletal
Double vision	Chest pain	Cold intolerance	Joint pain
Headaches	Leg swelling	Heat intolerance	Arthritis
Hearing loss	Palpitations	Excessive thirst	Muscle pain
Cataracts	Poor circulation	Excessive hunger	Joint swelling
Glaucoma	Cold hands		Muscle cramps
Dry eyes	Cold feet		Muscle weakness
Sinus problem			Joint stiffness
None	None	None	None

Gastrointestinal	Genitourinary	Neurological	Psychiatric
Abdominal pain	Bladder incontinence	Seizures	Depression
Trouble swallowing	Blood in urine	Dizziness	Anxiety
Heartburn	Urinary difficulty	Weakness	Mood swings
Nausea	Painful urination	Loss of balance	Memory problems
Vomiting	Urinary retention	Numbness	Nervousness
Constipation	Urinary urgency	Paralysis	Insomnia
None	None	None	None

Eyes	Environmental Allergies	Mouth
Dryness	Pollen	Bad breath
Discharge	Dust Mites	Bleeding gums
Double Vision	Pets/Animals	Sores – ulcers
Pain	Mold/Mildew	Dental problem
Redness	Metal	Loss of taste
None	None	None

Name: _____

VR-12 Health Survey

Instructions: These questions ask for your views about your health. Answer every question by marking 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.

1. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor

2. The following questions are about activities you might do during a typical day. Does **your health now limit** you in these activities? If so, how much?

   a. **Moderate activities** such as moving a table, pushing a vacuum, bowling or playing golf?

Yes, limited a lot	Yes, limited a little	No, not limited at all

   b. Climbing **several** flights of stairs?

Yes, limited a lot	Yes, limited a little	No, not limited at all

3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

   a. Accomplishing **less** than you would like.

None of the time	A little of the time	Some of the time	Most of the time	All of the time

   b. Were limited in the **kind** of work or other activities.

None of the time	A little of the time	Some of the time	Most of the time	All of the time

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

   a. Accomplishing **less** than you would like.

None of the time	A little of the time	Some of the time	Most of the time	All of the time

   b. Didn't do work or other activities as **carefully** as usual.

None of the time	A little of the time	Some of the time	Most of the time	All of the time

5. During the past 4 weeks, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely

6a. During the past 4 weeks, have you felt calm and peaceful?

All of the time	Most of the time	Good bit of the time	Some of the time	Little of the time	None of the time

6b. During the past 4 weeks, did you have a lot of energy?

All of the time	Most of the time	Good bit of the time	Some of the time	Little of the time	None of the time

6c. During the past 4 weeks, have you felt downhearted and blue?

All of the time	Most of the time	Good bit of the time	Some of the time	Little of the time	None of the time

1. During the past 4 weeks, how much of the time has your **physical health or emotional problems** interfered with your social activities (such as visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time

2. Compared to one year ago, how would you rate your **physical health** in general now?

Much better	Slightly better	About the same	Slightly worse	Much worse

3. Compared to one year ago, how would you rate your **emotional problems** (such as feeling anxious, depressed, or irritable) **now**?

Much better	Slightly better	About the same	Slightly worse	Much worse

Name: _____

LOWER EXTREMITY ACTIVITY SCALE

***Instructions**: Please read through each description given below, pick **ONE** description that best describes your regular daily activity and put a check in that box (only one box).*

CHECK ONLY ONE (1) BOX ON THIS PAGE:

☐ 1. I am confined to bed all day. (1)

☐ 2. I am confined to bed most of the day except for minimal transfer activities (going to the bathroom, etc.). (2)

☐ 3. I am either in bed or sitting in a chair most of the day. (3)

☐ 4. I sit most of the day, except for minimal transfer activities, no walking or standing. (4)

☐ 5. I sit most of the day, but I stand occasionally and walk a minimal amount in my house. (I may rarely leave the house for an appointment and may require the use of a wheelchair or scooter for transportation). (5)

☐ 6. I walk around my house to a moderate degree but I don't leave the house on a regular basis. I may leave the house occasionally for an appointment. (6)

☐ 7. I walk around my house and go outside at will, walking one or two blocks at a time. (7)

☐ 8. I walk around my house, go outside at will and walk several blocks at a time without any assistance (weather permitting). (8)

☐ 9. I am up and about at will in my house and can go out and walk as much as I would like with no restrictions (weather permitting). (9)

10. I am up and about at will in my house and outside. I also work outside the house in a:

- ☐ minimally (10)
- ☐ moderately (11)
- ☐ extremely active job (12)

11. I am up and about at will in my house and outside. I also participate in relaxed physical activity such as jogging, dancing, cycling, swimming:

- ☐ occasionally (2-3 times per month) (13)
- ☐ 2-3 times per week (14)
- ☐ daily (15)

12. I am up and about at will in my house and outside. I also participate in vigorous physical activity such as competitive level sports:

- ☐ occasionally (2-3 times per month) (16)
- ☐ 2-3 times per week (17)
- ☐ daily (18)

Overall Pain Level: (no pain 0 – 10 highest)

Right Knee

0	1	2	3	4	5	6	7	8	9	10

Left Knee

0	1	2	3	4	5	6	7	8	9	10

Name: _____