

New Patient Questionnaire – KNEE Adult Reconstruction & Joint Replacement



Name:		DOB:	Date:
Height:	Weight:	Age:	

Chief Complaint

Laterality Left Right Both

Please describe your symptoms: (Mark all that apply)

<input type="checkbox"/> Throbbing pain	<input type="checkbox"/> Radiating pain	<input type="checkbox"/> Dull pain	<input type="checkbox"/> Sharp pain
<input type="checkbox"/> Catching/Locking	<input type="checkbox"/> Swelling	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Instability
Other: _____			

Where is the pain located in your knee? (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? _____

How did it start? _____

What makes the pain better? _____

What makes the pain worse? _____

Have you EVER tried any prior conservative treatment?	Yes	No	How long?	Did it help?
Acupuncture or holistic remedies	<input type="radio"/>	<input type="radio"/>		
Arthroscopic surgery	<input type="radio"/>	<input type="radio"/>		
Brace / Cane / Crutches / Walker	<input type="radio"/>	<input type="radio"/>		
Cortisone injections	<input type="radio"/>	<input type="radio"/>		
Dietary supplements	<input type="radio"/>	<input type="radio"/>		
Viscosupplementation (Gel injections)	<input type="radio"/>	<input type="radio"/>		
NSAIDS (eg: Ibuprofen, Aspirin, Naproxen, Celebrex, Voltaren)	<input type="radio"/>	<input type="radio"/>		
Narcotics	<input type="radio"/>	<input type="radio"/>		
Physical therapy	<input type="radio"/>	<input type="radio"/>		
Weight loss	<input type="radio"/>	<input type="radio"/>		
Exercise program	<input type="radio"/>	<input type="radio"/>		
Activity modification / Lifestyle change	<input type="radio"/>	<input type="radio"/>		

Functional Assessment

What distance are you able to walk?

<input type="radio"/> Unlimited	<input type="radio"/> 10-20 blocks	<input type="radio"/> 5-10 blocks	<input type="radio"/> < 5 block	<input type="radio"/> House bound	<input type="radio"/> Unable
---------------------------------	------------------------------------	-----------------------------------	---------------------------------	-----------------------------------	------------------------------

How do you climb UP stairs?

<input type="radio"/> Normally	<input type="radio"/> With handrail for balance	<input type="radio"/> With handrail to pull myself up	<input type="radio"/> Unable
--------------------------------	---	---	------------------------------

How do you climb DOWN stairs?

<input type="radio"/> Normally	<input type="radio"/> With handrail for balance	<input type="radio"/> With handrail to support myself	<input type="radio"/> Unable
--------------------------------	---	---	------------------------------

What type of support do you use for walking?

<input type="radio"/> None	<input type="radio"/> Cane(s)	<input type="radio"/> Crutch(es)	<input type="radio"/> Walker
----------------------------	-------------------------------	----------------------------------	------------------------------

How do you get out of a chair?

<input type="radio"/> Normally	<input type="radio"/> Arm rest for balance	<input type="radio"/> Arm rest to push myself	<input type="radio"/> Unable
--------------------------------	--	---	------------------------------

Are you able to use public transportation?

<input type="radio"/> Yes	<input type="radio"/> No
---------------------------	--------------------------

Do you find this situation to be:

<input type="radio"/> Acceptable	<input type="radio"/> 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 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.

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?

<input type="radio"/> None	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	<input type="radio"/> Extreme
----------------------------	----------------------------	--------------------------------	------------------------------	-------------------------------

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

2. Twisting/pivoting on your knee:

<input type="radio"/> None	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	<input type="radio"/> Extreme
----------------------------	----------------------------	--------------------------------	------------------------------	-------------------------------

3. Straightening knee fully:

<input type="radio"/> None	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	<input type="radio"/> Extreme
----------------------------	----------------------------	--------------------------------	------------------------------	-------------------------------

4. Going up or down stairs:

<input type="radio"/> None	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	<input type="radio"/> Extreme
----------------------------	----------------------------	--------------------------------	------------------------------	-------------------------------

5. Standing upright:

<input type="radio"/> None	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	<input type="radio"/> 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 experience in the last week due to your knee.

6. Rising from sitting:

<input type="radio"/> None	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	<input type="radio"/> Extreme
----------------------------	----------------------------	--------------------------------	------------------------------	-------------------------------

7. Bending to floor/pick up an object:

<input type="radio"/> None	<input type="radio"/> Mild	<input type="radio"/> Moderate	<input type="radio"/> Severe	<input type="radio"/> Extreme
----------------------------	----------------------------	--------------------------------	------------------------------	-------------------------------

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

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		

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)

<input type="checkbox"/> Pain Pump	<input type="checkbox"/> Neurostimulator	<input type="checkbox"/> Pacemaker and/or Defibrillator	<input type="checkbox"/> 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

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
<input type="checkbox"/> Chills	<input type="checkbox"/> Easy bruising/bleeding	<input type="checkbox"/> Increased sputum	<input type="checkbox"/> Sores/ulcers
<input type="checkbox"/> Fever	<input type="checkbox"/> Blood clots in legs	<input type="checkbox"/> Cough	<input type="checkbox"/> Itching
<input type="checkbox"/> Sleep difficulty	<input type="checkbox"/> Blood clots in lungs	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Dryness
<input type="checkbox"/> Fatigue		<input type="checkbox"/> Wheezing	<input type="checkbox"/> Hives
<input type="checkbox"/> Night sweats		<input type="checkbox"/> Excessive snoring	<input type="checkbox"/> Rash
<input type="checkbox"/> Weight Change			<input type="checkbox"/> Mole changes
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None

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

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

Eyes	Environmental Allergies	Mouth
<input type="checkbox"/> Dryness	<input type="checkbox"/> Pollen	<input type="checkbox"/> Bad breath
<input type="checkbox"/> Discharge	<input type="checkbox"/> Dust Mites	<input type="checkbox"/> Bleeding gums
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Pets/Animals	<input type="checkbox"/> Sores - ulcers
<input type="checkbox"/> Pain	<input type="checkbox"/> Mold/Mildew	<input type="checkbox"/> Dental problem
<input type="checkbox"/> Redness	<input type="checkbox"/> Metal	<input type="checkbox"/> Loss of taste
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None

VR-12 Health Survey

Instructions: This questionnaire asks for your views about your health. Answer every question by marking the answer as indicated. If you are unsure how to answer a question, please give the best answer you can.

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

<input type="radio"/> Excellent	<input type="radio"/> Very Good	<input type="radio"/> Good	<input type="radio"/> Fair	<input type="radio"/> Poor
---------------------------------	---------------------------------	----------------------------	----------------------------	----------------------------

2. Does your health now limit:

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

<input type="radio"/> Yes, limited a lot	<input type="radio"/> Yes, limited a little	<input type="radio"/> No, not limited at all
--	---	--

b. Climbing several flights of stairs?

<input type="radio"/> Yes, limited a lot	<input type="radio"/> Yes, limited a little	<input type="radio"/> No, not limited at all
--	---	--

3. During the past 4 weeks, has your physical health resulted in:

a. Accomplishing less than you would like?

<input type="radio"/> None of the time	<input type="radio"/> A little of the time	<input type="radio"/> Some of the time	<input type="radio"/> Most of the time	<input type="radio"/> All of the time
--	--	--	--	---------------------------------------

b. Being limited in the kind of work or other activities you have attempted?

<input type="radio"/> None of the time	<input type="radio"/> A little of the time	<input type="radio"/> Some of the time	<input type="radio"/> Most of the time	<input type="radio"/> All of the time
--	--	--	--	---------------------------------------

4. During the past 4 weeks, as a result of any emotional problems (such as feeling depressed or anxious):

a. Have you accomplished less than you would like?

<input type="radio"/> None of the time	<input type="radio"/> A little of the time	<input type="radio"/> Some of the time	<input type="radio"/> Most of the time	<input type="radio"/> All of the time
--	--	--	--	---------------------------------------

b. Have you not completed work or other activities as carefully as usual?

<input type="radio"/> None of the time	<input type="radio"/> A little of the time	<input type="radio"/> Some of the time	<input type="radio"/> Most of the time	<input type="radio"/> 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 house work)?

<input type="radio"/> Not at all	<input type="radio"/> A little bit	<input type="radio"/> Moderately	<input type="radio"/> Quite a bit	<input type="radio"/> Extremely
----------------------------------	------------------------------------	----------------------------------	-----------------------------------	---------------------------------

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

<input type="radio"/> All of the time	<input type="radio"/> Most of the time	<input type="radio"/> Good bit of the time	<input type="radio"/> Some of the time	<input type="radio"/> Little of the time	<input type="radio"/> None of the time
---------------------------------------	--	--	--	--	--

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

<input type="radio"/> All of the time	<input type="radio"/> Most of the time	<input type="radio"/> Good bit of the time	<input type="radio"/> Some of the time	<input type="radio"/> Little of the time	<input type="radio"/> None of the time
---------------------------------------	--	--	--	--	--

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

<input type="radio"/> All of the time	<input type="radio"/> Most of the time	<input type="radio"/> Good bit of the time	<input type="radio"/> Some of the time	<input type="radio"/> Little of the time	<input type="radio"/> None of the time
---------------------------------------	--	--	--	--	--

9. 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...)?

<input type="radio"/> None of the time	<input type="radio"/> A little of the time	<input type="radio"/> Some of the time	<input type="radio"/> Most of the time	<input type="radio"/> All of the time
--	--	--	--	---------------------------------------

10. Compared to 1 year ago, how would you rate your physical health in general now?

<input type="radio"/> Much better	<input type="radio"/> Slightly better	<input type="radio"/> About the same	<input type="radio"/> Slightly worse	<input type="radio"/> Much worse
-----------------------------------	---------------------------------------	--------------------------------------	--------------------------------------	----------------------------------

11. Compared to 1 year ago, how would you rate your emotional problems now (such as feeling anxious, depressed or irritable)?

<input type="radio"/> Much better	<input type="radio"/> Slightly better	<input type="radio"/> About the same	<input type="radio"/> Slightly worse	<input type="radio"/> Much worse
-----------------------------------	---------------------------------------	--------------------------------------	--------------------------------------	----------------------------------

ACTIVITY SURVEY (LEAS)

Please read through each description given below, pick only ONE description that best describes your regular daily activities and put a check in that box.

CHECK ONLY ONE (1) BOX ON THIS PAGE

- a. I am confined to bed all day.
- b. I am confined to bed most of the day except for minimal transfer activities (going to the bathroom, etc)
- c. I am either in bed or sitting in a chair most of the day.
- d. I sit most of the day, except for minimal transfer activities, no walking or standing.
- e. 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.)
- f. 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.
- g. I walk around my house and go outside at will, walking one or two blocks at a time.
- h. I walk around my house, go outside at will and walk several blocks at a time without any assistance (weather permitting).
- i. 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).
- j. I am up and about at will in my house and outside. I also work outside the house in a:
- minimally
 - moderately
 - extremely active job
- k. 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)
 - 2-3 times per week
 - daily
- l. 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)
 - 2-3 times per week
 - daily