

# Knee Joint Replacement Pre-Op Form - Scott D. Anseth, MD

## STICKER FIELD

If there is **not any sticker available** please write the required data below:

Patient First Name:

Patient Last Name:

Medical Record Number:

Date of Birth:

What is patient's height?

Feet  Inches

What is patient's weight?

Pounds



Today's Date (MM/DD/YYYY)

		/			/				
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Planned Date of Surgery (MM/DD/YYYY)

		/			/				
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No Surgery or Treatment Scheduled Yet

Email: (Please provide your email address below for easy follow up and progress feedback)

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Site of your Knee Surgery:



- Right
- Left
- Bilateral
- N/A

Race/Ethnicity (optional question): Please select one

- White
- Black or African-American
- Hispanic or Latino
- Asian
- American Indian and Alaska Native
- Native Hawaiian and Other Pacific Islander
- Other



## Patient Demographics Information

**Education Level: Please select the highest level of education you have received**



- No schooling completed
- Less than 12<sup>th</sup> grade
- 12th grade, NO DIPLOMA
- High school DIPLOMA or the equivalent (for example: GED)
- Some college credit, but less than 1 year
- Associate degree (for example: AA, AS)
- Bachelor's degree (for example: BA, AB, BS)
- Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)
- Professional degree (for example: MD, DDS, DVM, LLB, JD)
- Doctorate degree (for example: PhD, EdD)

**Do you currently smoke cigarettes or use any other tobacco products ? (Mark one response.)**

- Yes
- No, I quit smoking or using any other tobacco products less than 6 months ago.
- No, I quit smoking or using any other tobacco products more than 6 months ago.
- No, I have never smoked or used any other tobacco products . (If you select this choice; PLEASE GO TO NEXT PAGE)

**How many years have you been smoking/using or did you smoke/use cigarettes or any other tobacco products?**

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 Years

**On average, how many packs of cigarettes/tobacco products do you or did you smoke each day?**

- ¼ pack per day or less (5 cigarettes or less)
- ½ pack per day
- 1 pack per day
- 1 ½ packs per day
- 2 packs or more per day

## Surgery History & Comorbidities

**Have you ever had any knee related surgeries previously?**

- Yes
- No (If you select this choice Please SKIP NEXT TWO QUESTIONS)

**How many surgeries did you have on your RIGHT KNEE?**

- None
- I had 1 surgery on my RIGHT KNEE
- I had 2 surgeries on my RIGHT KNEE
- I had 3 or more surgeries on my RIGHT KNEE

**How many surgeries did you have on your LEFT KNEE?**

- None
- I had 1 surgery on my LEFT KNEE
- I had 2 surgeries on my LEFT KNEE
- I had 3 or more surgeries on my LEFT KNEE

**Comorbidities:**

Do you have heart disease?

If you have heart disease, does it limit your activities?

Do you have lung disease?

If you have lung disease, does it limit your activities?

Do you have diabetes?

Do you have previous joint infection?

Do you have previous personal history of blood clot in the legs (DVT)?

Do you have previous personal history of blood clot traveling to your lungs (PE)?

Do you have fibromyalgia?

**YES**

**NO**

- |                       |                       |
|-----------------------|-----------------------|
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Under each heading, please fill ONE circle that best describes your health TODAY.

### Mobility



- I have no problems walking
- I have slight problems walking
- I have moderate problems walking
- I have severe problems walking
- I am unable to walk

### Self-Care

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

### Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities



### Pain/Discomfort

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

### Anxiety/Depression

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed



# EQ-5D-5L™ (continues)

• We would like to know how good or bad your health is TODAY.

• This scale is numbered from 0 to 100.

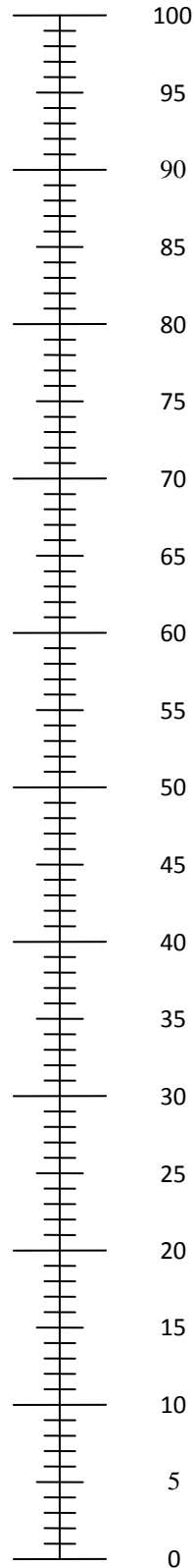
• 100 means the best health you can imagine.  
0 means the worst health you can imagine.

• Select a number on the scale to indicate how your health is TODAY.

• Now, please write the number you selected on the scale in the box ABOVE.



The best health  
you can imagine



Your Health Today (0-100)

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Please enter your health state score  
above

The worst health  
you can imagine

## OXFORD KNEE SCORE

The purpose of the Oxford Knee Score is to help assess the impact of your knee pain has had on your daily life in the PAST FOUR WEEKS. The following questions must ALL be answered on your experiences over the PAST FOUR WEEKS.

1. During the past four weeks; how would you describe the pain you usually have from your knee?

- None
- Very Mild
- Mild
- Moderate
- Severe



2. During the past four weeks; have you had any trouble with washing and drying yourself (all over) because of your knee?

- No trouble at all
- Very little trouble
- Moderate trouble
- Extreme difficulty
- Impossible to do



3. During the past four weeks; have you had any trouble getting in and out of a car or using public transportation because of your knee? (whichever you would tend to use)

- No trouble at all
- Very little trouble
- Moderate trouble
- Extreme difficulty
- Impossible to do

4. During the past four weeks; for how long have you been able to walk before pain from your knee becomes severe (with or without a cane)?

- No pain/ more than 30 minutes
- 16-30 minutes
- 5-15 minutes
- Around the house only
- Not at all – pain severe when walking



## OXFORD KNEE SCORE (continues)

5. During the past four weeks; after a meal (sitting at a table), how painful has it been for you to stand up from a chair because of your knee?

- Not at all painful
- Slightly painful
- Moderately painful
- Very painful
- Unbearable

6. During the past four weeks; have you been limping when walking because of your knee?

- Rarely/Never
- Sometimes, or just at first
- Often, not just at first
- Most of the time
- All of the time

7. During the past four weeks; could you kneel down and get up again afterwards?

- Yes, easily
- With little difficulty
- With moderate difficulty
- With extreme difficulty
- No, impossible

8. During the past four weeks; have you been troubled by pain from your knee in bed at night?

- No nights
- Only 1 or 2 nights
- Some nights
- Most nights
- Every night



## OXFORD KNEE SCORE (continues)

9. During the past four weeks; how much has pain from your knee interfered with your usual work? (including housework)

- Not at all
- A little bit
- Moderately
- Greatly
- Totally



10. During the past four weeks; have you felt that your knee might suddenly “give out” or let you down?

- Rarely/Never
- Sometimes, or just at first
- Often, not just at first
- Most of the time
- All of the time

11. During the past four weeks; could you do the grocery shopping on your own?

- Yes, easily
- With little difficulty
- With moderate difficulty
- With extreme difficulty
- No, impossible

12. During the past four weeks; could you walk down one flight of stairs?

- Yes, easily
- With little difficulty
- With moderate difficulty
- With extreme difficulty
- No, impossible

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## LOWER EXTREMITY ACTIVITY SCALE (LEAS)

**FIRST** read through each description given below.

Then Pick **ONLY ONE** description that best describes your regular daily activity TODAY.

**PLEASE SELECT ONLY ONE CHOICE.**



**Today**

**Activity Levels**

- I am confined to bed all day.
- I am confined to bed most of the day except for minimal transfer activities (going to the bathroom, etc.)
- I am either in bed or sitting in a chair most of the day.
- I sit most of the day, except for minimal transfer activities, no walking or standing.
- 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.)
- 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.
- I walk around my house and go outside at will, walking one or two blocks at a time.
- I walk around my house, go outside at will and walk several blocks at a time without any assistance (weather permitting).
- 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).
- I am up and about at will in my house and outside. I also work outside the house in a minimally active job.
- I am up and about at will in my house and outside. I also work outside the house in a moderately active job.
- I am up and about at will in my house and outside. I also work outside the house in an extremely active job.
- 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).
- 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 2-3 times per week.
- 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 daily.
- 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).
- I am up and about at will in my house and outside. I also participate in vigorous physical activity such as competitive level sports 2-3 times per week.
- I am up and about at will in my house and outside. I also participate in vigorous physical activity such as competitive level sports daily.



## VISUAL ANALOG PAIN SCALE (VAS) - KNEE PAIN

Indicate the severity of your knee pain level over PAST ONE WEEK by filling in any one circle that most applies to you from 0 "No Pain" to 10 "Worst Possible Pain".

**RIGHT Knee Pain - My pain level over PAST ONE WEEK with walking & activity:**

"0"  
No Pain

"10"  
Worst Possible Pain

**LEFT Knee Pain - My pain level over PAST ONE WEEK with walking & activity:**

"0"  
No Pain

"10"  
Worst Possible Pain

