New Mexico Center For Joint Replacement Surgery

Answer the following questions regarding your **overall** activity level.

Patient Name (First Initial - Middle Initial - Last Name) ☐ - ☐ - ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(MM-DD-YYYY)

Form Completion Date ☐☐ - ☐☐ - ☐☐☐☐

S.S.N ☐☐☐ - ☐☐ - ☐☐☐☐

Gender ☐ Male ☐ Female

Surgeon ☐☐☐

CHECK ONE

Right Hip ☐	Right Hip Surgery Date ☐☐ - ☐☐ - ☐☐☐☐
Left Hip ☐	Left Hip Surgery Date ☐☐ - ☐☐ - ☐☐☐☐
Right Knee ☐	Right Knee Surgery Date ☐☐ - ☐☐ - ☐☐☐☐
Left Knee ☐	Left Knee Surgery Date ☐☐ - ☐☐ - ☐☐☐☐

1. In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

The following items are about activities you might do during a typical day. ***Does your health now limit you in these activities?*** *If so, how much? (Check one box on each line)*

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. **Moderate Activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf:	☐	☐	☐
3. Climbing **several** flights of stairs:	☐	☐	☐

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**? (Check one box on each line)

	Yes	No
4. **Accomplished less** than you would like:	☐	☐
5. Were limited in the **kind** of work or other activities:	☐	☐

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)? (Check one box on each line)

	Yes	No
6. **Accomplished less** than you would like:	☐	☐
7. Didn't do work or other activities as **carefully** as usual:	☐	☐

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

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

These questions are about how you feel and how things have been with you ***during the past 4 weeks****. For each question, please give the one answer that comes closest to the way you have been feeling.*

How much of the time during the **past 4 weeks**...(Check one box on each line)

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
9. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
10. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
11. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

12. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your visiting with friends, relatives, etc.? (Check one box)

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

New Mexico Center For Joint Replacement Surgery

Pre-Op Patient Registration

PLEASE COMPLETE ONE FORM PER OPERATIVE SIDE

Patient Name (First Initial - Middle Initial - Last Name) ☐ - ☐ - ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

S.S.N. ☐☐☐ - ☐☐ - ☐☐☐☐

Gender ☐ Male ☐ Female

Surgeon ☐☐☐

CHECK ONE

☐ **Right hip** — **Right Hip Surgery Date** ☐☐ - ☐☐ - ☐☐☐☐

☐ **Left hip** — **Left Hip Surgery Date** ☐☐ - ☐☐ - ☐☐☐☐

☐ **Right knee** — **Right Knee Surgery Date** ☐☐ - ☐☐ - ☐☐☐☐

☐ **Left knee** — **Left Knee Surgery Date** ☐☐ - ☐☐ - ☐☐☐☐

1. Referred to this practice by: ____________________

2. List meds, dosage, how taken, for what problem:

3. Allergic to any meds, specify:

4. Previous surgeries (check all that apply):

☐ Appendectomy	☐ Bladder suspension	☐ Breast biopsy	☐ Carotid endarterectomy
☐ Cataract	☐ Cesarean section	☐ Cholecystectomy	☐ Excision herniated lumbar disc
☐ Heart bypass	☐ Hemorrhoidectomy	☐ Hernia repair	☐ Gastrointestinal surgery
☐ Hysterectomy	☐ Prostatectomy	☐ Thyroid surgery	☐ Removal skin lesion
☐ Tonsillectomy	☐ Tubal ligation	☐ TURP	☐ Vasectomy
☐ Vein stripping	☐ Exploratory laparoscopy		☐ Other

5. Specify other previous surgeries:

New Mexico Center For Joint Replacement Surgery

Pre-Op Patient Registration

PLEASE COMPLETE ONE FORM PER OPERATIVE SIDE

S.S.N. ☐☐☐ - ☐☐ - ☐☐☐☐

6. Primary healthcare provider: ____________ ____________

7. Specialist: ____________ ____________

8. Specialist: ____________ ____________

9. Specialist: ____________ ____________

10. Marital Status: ☐ Married ☐ Never married ☐ Divorced ☐ Separated ☐ Widowed

11. Number of children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

12. Do you ever drink alcohol: ☐ Yes ☐ No

13. Do you smoke now: ☐ Yes ☐ No

14. How many years have you smoked: ☐☐

15. Family History (does anyone in your family have):

☐ Back problems ☐ Kidney disease ☐ Lung problems ☐ High blood pressure
☐ Heart problems ☐ Artherosclerosis ☐ Major paralysis or neurologic problems
☐ Diabetes ☐ Cancer diagnoses ☐ Ulcer ☐ Any bleeding problems
☐ Liver disease ☐ Depression ☐ Rheumatoid arthritis ☐ Osteoarthritis or degenerative arthritis
☐ Previous anesthesia problems ☐ Other medical problem

16. Specify other medical problem:

☐

New Mexico Center For Joint Replacement Surgery

Pre-Op Patient Registration

PLEASE COMPLETE ONE FORM PER OPERATIVE SIDE

S.S.N. ☐☐☐ - ☐☐ - ☐☐☐☐

Please indicate which of the following health problems you have.

17. Back problems: ☐ Yes ☐ No

18. Lung problems: ☐ Yes ☐ No

19. High blood pressure: ☐ Yes ☐ No

20. Heart problems: ☐ Yes ☐ No

21. Hardening of the arteries: ☐ Yes ☐ No

22. Previous blood clots: ☐ Yes ☐ No

23. Previous pulmonary embolus: ☐ Yes ☐ No

24. Major paralysis or neurologic problems: ☐ Yes ☐ No

25. Diabetes: ☐ Yes ☐ No

26. Cancer diagnoses: ☐ Yes ☐ No

27. Ulcer: ☐ Yes ☐ No

28. Kidney disease: ☐ Yes ☐ No

29. Bleeding problems: ☐ Yes ☐ No

30. Liver disease ☐ Yes ☐ No

31. Depression: ☐ Yes ☐ No

32. Rheumatoid arthritis: ☐ Yes ☐ No

33. Hiatal hernia: ☐ Yes ☐ No

34. Constipation or diarrhea: ☐ Yes ☐ No

35. Anemia: ☐ Yes ☐ No

36. Fractures or joint injuries: ☐ Yes ☐ No

37. Osteoarthritis or degenerative arthritis: ☐ Yes ☐ No

38. Previous anesthesia problems: ☐ Yes ☐ No

39. Recent weight gain or loss: ☐ Yes ☐ No

40. Other medical problems: ☐ Yes ☐ No

41. Other common health problems:

42. Height (in) ☐☐☐

43. Weight (lbs) ☐☐☐

PLEASE COMPLETE ONE FORM PER OPERATIVE SIDE

S.S.N. ☐☐☐ - ☐☐ - ☐☐☐☐

Activity Level

44. If pain in joints, when does it hurt:
☐ Never ☐ Only occasionally or intermittently
☐ Only when I first get up from a sitting or standing position
☐ Only when I walk more than 30 minutes
☐ Anytime I walk ☐ At all times

45. Pain Scale: 0 = No pain/10 = Severe pain:
☐ 0 - No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 - Severe pain

46. Current general activity level:
☐ I am bedridden or confined to a wheelchair
☐ I am sedentary (in a chair) with minimal capacity for walking or other activity
☐ I am partially sedentary and can do desk work/light housekeeping or bench work
☐ I perform light labor such as heavy house cleaning/assembly line work/yard work/or light sports
☐ I perform moderate manual labor with lifting heavy weight and/or participate in moderate sports
☐ I participate in heavy manual labor/frequently lift heavy weights or participate in vigorous sports

47. Physical therapy for arthritis:
☐ Never ☐ Less than once per week ☐ Once per week ☐ More than once per week but not daily ☐ Every day

48. Number of time had joint injections (steroid) for arthritis:
☐ None ☐ 1 ☐ 2 ☐ 3 ☐ More than 3

49. During past week how often taken pain medications:
☐ 3 or more times a day ☐ Once or twice a day ☐ Once every couple of days ☐ Once ☐ Not at all

50. During past 6 months did you take NSAIDS medication: ☐ Yes ☐ No

51. During past 6 months taken any narcotic pain medication for arthritis: ☐ Yes ☐ No

52. Do you use a walking aid: ☐ Yes ☐ No

53. If using a walking aid, why:
☐ Hip pain/discomfort ☐ Knee pain/discomfort
☐ Other joint problems ☐ Stability

New Mexico Center For Joint Replacement Surgery

Pre-Op Hip Patient Questionnaire

● Right hip

PLEASE COMPLETE ONE FORM PER OPERATIVE SIDE

Patient Name (First Initial - Middle Initial - Last Name)

☐ - ☐ - ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Surgery ☐☐ - ☐☐ - ☐☐☐☐ (MM-DD-YYYY)

Gender ☐ Male ☐ Female

S.S.N. ☐☐☐ - ☐☐ - ☐☐☐☐

Surgeon ☐☐☐

1. How long have you had the hip problem:

☐ 0-3 months ☐ 1-2 years ☐ 3-6 months ☐ 2-5 years ☐ 6-12 months ☐ > 5 years

2. Which of these categories would best describe your hip pain:

☐ None/ignore ☐ Slight/occasional/no compromise in activity

☐ Mild/no effect on ordinary activity/pain after unusual activity/use aspirin

☐ Moderate/tolerable/make concessions/use occasional codeine

☐ Marked/serious limitations ☐ Totally disabled

3. Do you need support when walking:

☐ None ☐ Cane/long walks ☐ Cane/full time ☐ Crutch

☐ 2 Canes ☐ 2 crutches ☐ Walker ☐ Unable to walk

4. How do you go up and down stairs:

☐ Normally (one foot on each step) ☐ Normally with banister

☐ Any method (both feet on same step) ☐ Not able

5. How do you put on shoes and socks: ☐ With ease ☐ With difficulty ☐ Unable

6. How long can you sit in a chair: ☐ Any chair/1 hour ☐ High chair/1/2 hour ☐ Unable to sit in any chair/1/2 hour

7. How much do you limp without support: ☐ None ☐ Slight ☐ Moderate ☐ Severe ☐ Unable to walk

8. Are you able to use public transporation such as a bus or subway if you wanted to: ☐ Yes ☐ No

9. Does this hip interfere with sleeping: ☐ Yes ☐ No

10. Do you feel your legs are the same length:

☐ Legs are equal ☐ Right leg is shorter than left ☐ Left leg is shorter than right

11. How far can you walk without stopping because of hip pain:

☐ Unlimited ☐ 6 blocks ☐ 2-3 blocks ☐ Indoors only ☐ Bed and chair

New Mexico Center For Joint Replacement Surgery

General Physical Exam/ Evaluation and Treatment

PLEASE COMPLETE ONE FORM PER OPERATIVE SIDE

Patient Name (First Initial - Middle Initial - Last Name) ☐ - ☐ - ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

S.S.N. ☐☐☐ - ☐☐ - ☐☐☐☐

Gender ☐ Male ☐ Female

Surgeon ☐☐☐

CHECK ONE

☐ **Right hip** — **Right Hip Surgery Date** ☐☐ - ☐☐ - ☐☐☐☐

☐ **Left hip** — **Left Hip Surgery Date** ☐☐ - ☐☐ - ☐☐☐☐

☐ **Right knee** — **Right Knee Surgery Date** ☐☐ - ☐☐ - ☐☐☐☐

☐ **Left knee** — **Left Knee Surgery Date** ☐☐ - ☐☐ - ☐☐☐☐

1. Systemic Illnesses/comorbidities: ☐ Yes ☐ No

2. If there were systemic illnesses/comorbidities, check all that apply:

☐ Alcohol ☐ Cancer ☐ Cardiac ☐ Endocrine (Diabetes Mellitus) ☐ Gastrointestinal

☐ Genitourinary ☐ Hematologic ☐ Hepatabiliary ☐ Hypertension ☐ Infectious disease

☐ Neurological ☐ Obesity >= 20% ☐ Osteoporosis ☐ Parkinson's disease ☐ Psychiatric

☐ Respiratory ☐ Smoking ☐ Steriods ☐ Thromboembolis disease ☐ Vascular ☐ Other

3. If other system illnesses/comorbidities, specify ____________________

4. Charnley classification: ☐ Unilateral joint no other disability ☐ Bilateral joint no other disability

☐ Unilateral or bilateral with other joints or medical conditions affecting function

5. Expected activity level: ☐ Bed to chair ☐ Household ambulator ☐ Community ambulator

☐ No walking limit ☐ Sports/heavy work

6. Health/physical status classification:

☐ Poor (ASA 4) Decompensated diseases/short life expectancy

☐ Fair (ASA 3) Fair control of chronic diseases

☐ Moderate (ASA 2-) Medications controlling chronic diseases

☐ Good (ASA 2+) No medications/History of chronic medical problems but under control

☐ Excellent (ASA 1) No medications/No chronic illness

New Mexico Center For Joint Replacement Surgery

General Physical Exam/ Evaluation and Treatment

PLEASE COMPLETE ONE FORM PER OPERATIVE SIDE

S.S.N. ☐☐☐ - ☐☐ - ☐☐☐☐

7. Planned Pre-Operative Hip Procedure-Right:

☐ Primary THR ☐ Revision THR - Acetabular Components ☐ Revision THR - Femoral Component
☐ Conversion of Previous Surgery to THR ☐ Preparation and Insertion of buld allograft
☐ Removal of Hardware ☐ Resection Arthroplasty

8. Planned Pre-Operative Hip Procedure-Left:

☐ Primary THR ☐ Revision THR - Acetabular Components ☐ Revision THR - Femoral Component
☐ Conversion of Previous Surgery to THR ☐ Preparation and Insertion of buld allograft
☐ Removal of Hardware ☐ Resection Arthroplasty

9. Planned Pre-Operative Knee Procedure-Right:

☐ Primary TKR with patella ☐ Revision TKR-Patellar component ☐ Revision TKR - Tibial component
☐ Revision TKR - Femoral component ☐ Medial Unicompartmental Knee replacement
☐ Lateral Unicompartmental Knee replacement ☐ Conversion of Previous Surgery to TKR
☐ Resection Arthroplasty ☐ Prep and insertion of bulk allograft

10. Planned Pre-Operative Knee Procedure-Left:

☐ Primary TKR with patella ☐ Revision TKR-Patellar component ☐ Revision TKR - Tibial component
☐ Revision TKR - Femoral component ☐ Medial Unicompartmental Knee replacement
☐ Lateral Unicompartmental Knee replacement ☐ Conversion of Previous Surgery to TKR
☐ Resection Arthroplasty ☐ Prep and insertion of bulk allograft

New Mexico Center For Joint Replacement Surgery

Pre-Op Hip Physical Exam
• Right Hip

PLEASE COMPLETE ONE FORM PER OPERATIVE SIDE

Patient Name (First Initial - Middle Initial - Last Name) ☐ - ☐ - ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

S.S.N. ☐☐☐ - ☐☐ - ☐☐☐☐

Gender ☐ Male ☐ Female

Date of Surgery ☐☐ - ☐☐ - ☐☐☐☐ (MM-DD-YYYY)

Surgeon ☐☐☐

1. Associated conditions with arthritis: ☐ Yes ☐ No

2. If there were associated conditions with arthritis, check all that apply:

- ☐ Ankylosing spondylitis
- ☐ Congenital hip dysplasia
- ☐ Gout
- ☐ Hemochromatosis
- ☐ Juvenile rheumatoid arthritis
- ☐ Legg-Calve-Perthes
- ☐ Osteochondritis dissecans
- ☐ Osteonecrosis
- ☐ Paget's disease
- ☐ Pigmented villondular synovitis
- ☐ Post septic
- ☐ Post traumatic
- ☐ Protrusio
- ☐ Pseudogout
- ☐ Psoriasis
- ☐ Rheumatoid arthritis
- ☐ Slipped capital femoral epiphysis
- ☐ Systemic lupus erythematous
- ☐ Other

3. If other associated conditions, specify: ☐

4. Pulses Intact: ☐ Yes ☐ No

5. Specify Pulses Not Intact: ☐

6. Neurological Status Intact: ☐ Yes ☐ No

7. Specify Neurological Status Not Intact: ☐

8. Tenderness (check all that apply):

- ☐ Thigh
- ☐ Groin
- ☐ Lateral
- ☐ Posterior
- ☐ Greater Trochanter
- ☐ Sacriliac
- ☐ Back/lumbar spine

9. Skin Status: (Check All That Apply) ☐ Normal ☐ Previous incision ☐ Abnormal (Specify abnormality): ☐

10. Previous hip operations: ☐ Yes ☐ No

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New Mexico Center For Joint Replacement Surgery

Pre-Op Hip Physical Exam
Right Hip

PLEASE COMPLETE ONE FORM PER OPERATIVE SIDE

S.S.N. ☐☐☐ - ☐☐ - ☐☐☐☐

11. Specify Previous Operations

- ☐ Bi/uni replace
- ☐ Bone graft femoral neck
- ☐ Core decompress
- ☐ Curettage tumor
- ☐ Fusion
- ☐ Girdlestone resection
- ☐ Multi revsion THR
- ☐ ORIF head fracture
- ☐ ORIF femoral head fracture
- ☐ ORIF femoral neck fracture
- ☐ ORIF intertroch. fracture
- ☐ ORIF other femur fracture
- ☐ Pelvis osteotomy
- ☐ Proxi. femoral osteotomy
- ☐ Revise acet. cup
- ☐ Revise femoral stem
- ☐ Revise THR (acet and femur)
- ☐ Surface replace
- ☐ Total hip replace
- ☐ Troch. advance
- ☐ Resurface arthroplasty
- ☐ Other

12. Specify other hip operations: ☐

13. Previous hip infection: ☐ Yes ☐ No

14. Range of Motion (degrees) - Operative Side (All Measurements Active Assisted, Supine, Goniometer)

Fixed Flexion: ☐☐☐ °
Abduction: ☐☐☐ °
External Rotation in Extension: ☐☐☐ °

Further Flexion to: ☐☐☐ °
Adduction: ☐☐☐ °
Internal Rotation in Extension: ☐☐☐ °

15. Deformity (operative side): ☐ Fixed ADD >= 10 degrees ☐ Leg Length Discrepancy >= 3.5cm ☐ Fixed IRE >= 10 degrees ☐ PFC >= 30 degrees ☐ None of the above

16. Trendelenburg: ☐ Positive ☐ Level/equivocal ☐ Negative ☐ Unable to Test

17. True Length Discrepancy: ☐ Legs Equal ☐ Right Short ☐ Left Short

If Right or Left Short Specify: True: ☐☐ mm

18. Limp without Support: ☐ No Limp ☐ Slight ☐ Moderate ☐ Severe ☐ Unable to Walk ☐ N/A (always use support)

19. On which side does patient limp: ☐ Right ☐ Left ☐ Both ☐ N/A (does not limp)