

**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)

**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  
 -  -

Form Completion Date  -  -

S.S.N  -  -

Gender  Male  Female Surgeon

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: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Climbing several flights of stairs:                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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:                | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Were limited in the kind of work or other activities: | <input type="checkbox"/> | <input type="checkbox"/> |

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:                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Didn't do work or other activities as carefully as usual: | <input type="checkbox"/> | <input type="checkbox"/> |

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?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Did you have a lot of energy?       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you felt downhearted and blue? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

# Post-Op Knee Assessment

For

## Joint Replacement Surgery

PLEASE COMPLETE ONE FORM PER OPERATIVE SIDE

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

-  -

Date of Surgery

-  -

(MM-DD-YYYY)

Operative Side  Left  Right

Gender  Male  Female

Form Completion Date

S.S.N.  -  -

Surgeon

-  -

Post Op Exam Period  6 Weeks  3 Months  6 Months  1 Year  2 Year  3 Year

Specified Years

4 Year  5 Year  6 Years  7 Years  8 Years  Specify Years

### 1. Ability to rise from chair:

- Able with ease (no arms)
- Able with ease (with arms)
- Able with difficulty
- Unable

### 2. Ability to get in and out of automobile:

- Able including opening and closing door
- Needs assistance of another person to get in
- Needs assistance of another person to get out
- Needs assistance of another person to get in and out
- Unable even with assistance

### 3. What is the patient's activity level?

- Regularly participate in impact sports (jogging, tennis, skiing, acrobatic, ballet, heavy labor, or backpacking)
- Sometimes participate in impact sports
- Regularly participate in very active events
- Regularly participate in active events
- Regularly participate in moderate activities (swimming, unlimited housework or shopping)
- Sometimes participate in moderate activities
- Regularly participate in mild activities (walking, limited housework, and limited shopping)
- Sometimes participate in mild activities
- Mostly inactive (restricted to minimal activities of daily living)
- Wholly inactive (dependent on others; cannot leave residence)

### 4. Does the patient have knee pain?

- None
- Mild
- Moderate
- Severe

If Yes, Identify Area of Pain  
If No, Form is Complete

- Anterior
- Posterior
- Medial
- Lateral
- Entire Knee

Joint Replacement Surgery

PLEASE COMPLETE ONE FORM PER OPERATIVE SIDE

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

Grid for patient name input

Date of Surgery

Grid for date of surgery input

(MM-DD-YYYY)

Gender Male Female

Form Completion Date

S.S.N. Grid

Surgeon Grid

Form completion date grid

- 1. Skin Status: (Check All That Apply) Healed Not Healed Erythema Warmth Soft Tissue Swelling Other
2. Dependent Edema: Yes No
3. Pulses Intact: Yes No
4. Specify Pulses Not Intact:
5. Neurological Status Intact: Yes No
6. Specify Neurological Status Not Intact:
7. Effusion: None Mild/Moderate Moderate/Severe
8. Patella: Neutral Subluxed Dislocated Absent
9. Patello-Femoral Crepitus/Clicking: None Mild/Moderate Severe/Extreme
10. Limp W/O Support: No Limp Slight Moderate Severe Unable to walk N/A (always use support)
If Limp, Specify Side: Right Left Both
11. Quadricep Muscle Strength: Excellent Good Fair Poor
12. Range of Motion: (All Measurements Sitting, Goniometer, Lateral Knee) Full Extension=0 Hyperextension is recorded as negative degrees. Fixed flexion contracture is recorded as positive degrees. Maximum Active Flexion
13. Extension Lag: Present if passive knee extension is greater than active knee
14. Tibio-Femoral Alignment: From Radiograph - Anatomical Angle Neutral Valgus Varus
15. A/P Instability/Laxity(at 90 degrees): mm
16. A/P Instability/Laxity(at full extension): mm
17. Medial Instability/Laxity with Valgus Stress: mm
18. Lateral Instability/Laxity with Varus Stress: mm
19. Complications? Yes No
If Yes, Complete Complication Report Form