New Patient Questionnaire – KNEE

Adult Reconstruction & Joint Replacement

HOSPITAL FOR SPECIAL SURGERY

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

Chief Complaint

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 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	◯	◯		.
Arthroscopic surgery	◯	◯		.
Brace / Cane / Crutches / Walker	◯	◯		.
Cortisone injections	◯	◯		.
Dietary supplements	◯	◯		.
Viscosupplementation (Gel injections)	◯	◯		.
NSAIDS *(eg: Ibuprofen, Aspirin, Naproxen, Celebrex, Voltaren)*	◯	◯		.
Narcotics	◯	◯		.
Physical therapy	◯	◯		.
Weight loss	◯	◯		.
Exercise program	◯	◯		.
Activity modification / Lifestyle change	◯	◯		.

Functional Assessment

What distance are you able to walk?

○ Unlimited	○ 10-20 blocks	○ 5-10 blocks	○ < 5 block	○ House bound	○ Unable

How do you climb **UP** stairs?

○ Normally	○ With handrail for balance	○ With handrail to pull myself up	○ Unable

How do you climb **DOWN** stairs?

○ Normally	○ With handrail for balance	○ With handrail to support myself	○ Unable

What type of support do you use for walking?

○ None	○ Cane(s)	○ Crutch(es)	○ Walker

How do you get out of a chair?

○ Normally	○ Arm rest for balance	○ Arm rest to push myself	○ Unable

Are you able to use public transportation?

○ Yes	○ No

Do you find this situation to be:

○ Acceptable	○ Unacceptable

KOOS, JR. Knee Survey

Instructions: This survey asks for you 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?

○ 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 experience 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

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 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)

☐ 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

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