Form For Patients Considering Total Knee Replacement

Patient Name: _____ Date of Evaluation: _____

I am _____ years old; ☐ male or ☐ female; _____ft. _____ in. tall; and weigh _____ lbs.; (_____BMI)
My worst knee is ☐ right, ☐ left, or ☐ both.
My knee has hurt and poorly functioned for _____ years _____ months.

I tried the following treatments (check the box):

☐ I tried losing weight and lost _____ pounds.
☐ I used Motrin, Aleve or other anti-inflammatory agents during the last_____ months.
☐ I have difficulty walking, bathing, showering, dressing, shopping, cleaning, cooking (ADLs).
☐ I tried or completed 12 exercise sessions of stretching or conditioning.
☐ I tried or completed 12 physical therapy visits.
☐ I had one or more shots in my knee.
☐ I used a brace during the last_____ months.
☐ I used a cane, crutches, or walker during the last _____ months.
☐ I had arthroscopic surgery on my knee.
☐ I had multiple operations on my knee.
☐ I am bringing x-rays of my knees taken on_____

_____ _____
Signature Date

Side of Surgery: Left or Right DOS: _____ Dictation #: _____

	PREOP (Left/Right)	POSTOP 4-5 Weeks	POSTOP ____mo	POSTOP ____mo	POSTOP ____yrs	POSTOP ____yrs
Date of Visit						
Physical SF-12						
Mental SF-12						
Oxford Score	/					
KSS	/					
Knee Function						
Extension	/					
Flexion	/					
Varus Deformity	/					
Valgus Deformity	/					
ESR						
CRP						
Leucocyte Esterase Test						

Dictation #: _____