

Today's Date: _____ / _____ / _____
month day year

104.49

Patient ID _____

Physician ID _____

Clinic/Site ID _____

Form filled out by (check one):

Physician NP/PA

Resident Other

0.0.0, 104.52, 104.53, 101.6

PHYSICIAN PRE-OP FORM

HIP REPLACEMENT 13.2

TO BE COMPLETED BY PHYSICIAN PRIOR TO SURGERY

- 1. Measured patient height: _____ inches 104.179
- 2. Measured patient weight: _____ lbs 104.180
- 3. Diagnosis at time of original hip replacement: *(for preoperative use-check all that apply)*
 - a. Osteoarthritis 100.1456.1-
 - 1) Primary 100.1456.9
 - 2) Secondary (e.g., Legg Perthes, congenital dysplasia and dislocation of hip)
 - b. Inflammatory arthritis (e.g., rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis)
 - c. Fracture
 - 1) Acute (e.g., Fx femoral head [with/without dislocation], Fx femoral neck, Fx shaft of femur)
 - 2) Old or Remote (failure of fixation, nonunion)
 - d. Osteonecrosis (e.g., idiopathic, post traumatic, steroid associated)
 - e. Deposition/metabolic disease and metabolic bone disease (e.g., gout, chondrocalcinosis/pseudogout, hemophilia, Pagets)
 - f. Arthritis associated with an old infection
 - g. Neoplasia or Tumor

Previous hip surgery

4. Is the planned procedure a) Primary THA b) Revision THA
- | | | |
|--|-----------|-----------|
| | ___ Right | ___ Right |
| | ___ Left | ___ Left |
| | ___ Both | ___ Both |
- 104.181

5. Prior surgical procedures	<u>Right</u>	<u>Left</u>	<u>Both</u>	
a. Internal fixation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	104.182
b. Cup arthroplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Osteotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Arthrodesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Girdlestone procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Femoral hemiarthroplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Surface replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
h. Bipolar femoral replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
i. Total hip replacement (THR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
j. None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

6. Number of previous arthroplasty procedures on femoral side
(if none, enter 0) _____ 104.183

7. Number of previous arthroplasty procedures on acetabular side
(if none, enter 0) _____ 104.184

8. Medications:
During the **past four weeks** has the patient taken any of the following medications on a regular basis? 100.1474

	Yes	No
a. Anti-inflammatory drugs (e.g., aspirin compounds, butazolidin, naproxen, ibuprofen, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
b. Oral steroids (prednisone, dexamethasone, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
c. Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
d. Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>
e. DMARD [gold (parenteral or oral), Plaquenil (hydroxychlorine) methotrexate, cyclophosphamide, azathioprine, penicillamine, etc.]	<input type="checkbox"/>	<input type="checkbox"/>
f. Narcotic analgesics	<input type="checkbox"/>	<input type="checkbox"/>

9. Indications for surgery: (check all that apply) 100.1475

	Yes	No
a. Progression of disease		
1) Clinical	<input type="checkbox"/>	<input type="checkbox"/>
2) Radiologic	<input type="checkbox"/>	<input type="checkbox"/>
b. Failure of previous operations other than THR	<input type="checkbox"/>	<input type="checkbox"/>
c. Complication of previous THR (if yes, specify below)	<input type="checkbox"/>	<input type="checkbox"/>
1) Loosening	<input type="checkbox"/>	
2) Dislocation	<input type="checkbox"/>	
3) Fracture	<input type="checkbox"/>	
4) Infection	<input type="checkbox"/>	
5) Other	<input type="checkbox"/>	

10. Pre-op lab tests: 100.1476

a. Hematocrit _____ % Not done

b. Albumin _____ g/dl Not done

11 Sources of infection that could influence outcome of THR: (check all that apply)

- a. None apparent 101.104
- b. Chronic respiratory infection
- c. Urinary tract infection
- d. Poor dental hygiene (gingivitis/abscess/oral surgery)
- e. Skin breakdown

12. Range of motion of hips:
(Any of the following are applicable: in 0° hip flexion, maximum extension, or 90° flexion, depending on operative approach)

104.185.1-
104.185.10

- | | Left
hip | Right
hip |
|-------------------------------------|--------------------------|--------------------------|
| a. Fixed flexion | ____° | ____° |
| b. Further flexion to | ____° | ____° |
| c. Abduction/adduction | ____°/____° | ____°/____° |
| d. External/internal rotation | ____°/____° | ____°/____° |
| e. Did not measure | <input type="checkbox"/> | <input type="checkbox"/> |

13. Leg lengths: (check box if equal, or fill in the discrepancy in cm if unequal)

100.1482

- Equal length
- Short right ____ . ____ (cm)
- Short left ____ . ____ (cm)

Measured:

- Radiologically
- On blocks
- Clinically
- Direct measure
- Not measured

100.1482.4

14. Other disabling joint diseases that could affect the outcome of THR: (check all that apply)

100.1483

- a. None
- b. Back
- c. Contralateral hip
- d. Ipsilateral knee
- e. Contralateral knee
- f. Ipsilateral upper extremity
- g. Contralateral upper extremity

15. Trendelenburg sign

104.186

- | | Left | Right |
|----------------|--------------------------|--------------------------|
| Positive | <input type="checkbox"/> | <input type="checkbox"/> |
| Negative | <input type="checkbox"/> | <input type="checkbox"/> |
| Not done | <input type="checkbox"/> | <input type="checkbox"/> |

16. Trendelenburg lurch (abductor lurch or Duchenne sign) Present Absent Not done

104.187