

DATE OF PATIENT VISIT: ____ / ____ / ____ 104.215
month day year

1. MEDICATIONS: During the **past four weeks**, has the patient taken any of the following medications on a regular basis? (check all that apply): 104.231

- a. Anti-inflammatory drugs (e.g. aspirin compounds (>325mg/day), butazolidin, naproxen, ibuprofen, etc.)
- b. Oral steroids (prednisone, dexamethasone, etc.)
- c. Antibiotics
- d. Anticoagulants
- e. DMARD [gold-parenteral or oral, Plaquenil (hydroxychlorine) methotrexate, cyclophosphamide, azathioprine, penicillamine, etc.]
- f. Narcotic analgesic (codeine, oxycodone, etc.)
- g. None

2. DEGREE OF LIMP (check one for each row): 100.827

- | | None | Slight | Moderate | Severe | Unable to Walk |
|--------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Without support | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. With support | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. Has the patient been hospitalized since the last evaluation (excluding outpatient procedures) (check one): 104.232

- a. No
- b. Yes, for reasons related to Total Joint Replacement
- c. Yes, for reasons unrelated to Total Joint Replacement

4. COMPLICATIONS SINCE LAST VISIT (check all that apply): 104.233

- | | R | L |
|--|--------------------------|--------------------------|
| a. None | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Delayed wound healing | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Dislocation/subluxation | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Fracture | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Hematoma | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Hemarthrosis | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Hemorrhage | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Infection (superficial) | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Infection (articular) | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Instability | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Loosening | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Reoperation/Revision | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Stiffness resulting in manipulation | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Peroneal nerve palsy | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Pulmonary embolus | <input type="checkbox"/> | <input type="checkbox"/> |
| p. Wear | <input type="checkbox"/> | <input type="checkbox"/> |
| q. Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

5. KNEE FLEXION CONTRACTURE (degrees) (check one for each row):

100.807

	0-4	5-9	10-14	15-19	20-29	30+	Not Measured
a. Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. KNEE EXTENSION LAG (degrees) (check one for each row):

100.808

	0	1-9	10-19	20-29	30+	Not Measured
a. Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. KNEE MAXIMAL FLEXION (degrees) (check one for each row):

100.900

	<60	60-79	80-99	100-119	120+	Not Measured
a. Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. KNEE MEDIOLATERAL WEIGHT BEARING ALIGNMENT (degrees) (standing)
(check one for each row):

104.219

	Varus 1-5	Varus 9-14	Varus 15+	Valgus 0-4	Valgus 5-9	Valgus 10-14	Valgus 15 +	Not Measured
a. Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. KNEE ANTERIORPOSTERIOR STABILITY (Maximum degrees of movement
in any position) (check one for each row):

100.810

	0-4mm	5-9mm	10+mm	Not Measured
a. Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. KNEE MEDIOLATERAL STABILITY (Maximum degrees of movement in any
position) (check one for each row):

100.811

	0-4	5-9	10-14	15+	Not Measured
a. Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>