

Patient ID	_____
Physician ID	_____
Clinic/Site ID	_____
Form filled out by (check one):	
<input type="checkbox"/> Physician _____	<input type="checkbox"/> NP/PA _____
<input type="checkbox"/> Resident _____	<input type="checkbox"/> Other _____

0.0.0, 104.52, 104.53, 101.6

# Physician Pre-op Evaluation

## TOTAL KNEE REPLACEMENT FORM 16.2

TO BE COMPLETED BY **PHYSICIAN** DURING LAST VISIT PRIOR TO SURGERY

Original by Robert F. Meenan, M.D., M.P.H. and Lewis E. Kazis, Sc.D.  
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DATE OF PATIENT VISIT: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_  
month day year

104.215

1. OPERATIVE JOINT (check one): a. Right  b. Left  c. Bilateral  100.836

2. DATE OF SURGERY: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ 104.191  
month day year

3. PATIENT'S PRESENT HEIGHT : \_\_\_\_\_ ft. \_\_\_ \_\_\_ inches Not Measured  100.388

4. PATIENT'S PRESENT WEIGHT: \_\_\_ \_\_\_ \_\_\_ lbs. Not Measured  100.388

5. PREVIOUS KNEE PROCEDURES (check all that apply):

	Right	Left	
a. None	<input type="checkbox"/>	<input type="checkbox"/>	
b. Arthrodesis	<input type="checkbox"/>	<input type="checkbox"/>	
c. Total knee arthroplasty	<input type="checkbox"/>	<input type="checkbox"/>	
d. Unicompartmental, knee arthroplasty (lateral or medial)	<input type="checkbox"/>	<input type="checkbox"/>	
e. Unicompartmental, knee arthroplasty (patello-femoral)	<input type="checkbox"/>	<input type="checkbox"/>	
f. Arthroscopy (Diagnostic)	<input type="checkbox"/>	<input type="checkbox"/>	
g. Chondroplasty	<input type="checkbox"/>	<input type="checkbox"/>	104.440
h. Ligament reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	
i. Meniscectomy	<input type="checkbox"/>	<input type="checkbox"/>	
j. ORIF	<input type="checkbox"/>	<input type="checkbox"/>	
k. Osteotomy-Distal femur	<input type="checkbox"/>	<input type="checkbox"/>	
l. Osteotomy-Proximal tibia	<input type="checkbox"/>	<input type="checkbox"/>	
m. Patellectomy	<input type="checkbox"/>	<input type="checkbox"/>	
n. Patellar realignment	<input type="checkbox"/>	<input type="checkbox"/>	
o. Synovectomy	<input type="checkbox"/>	<input type="checkbox"/>	
p. Other procedure	<input type="checkbox"/>	<input type="checkbox"/>	

6. NUMBER OF PREVIOUS TOTAL KNEE ARTHROPLASTY PROCEDURES (check one for each column):

	Right	Left	
a. None	<input type="checkbox"/>	<input type="checkbox"/>	
b. One	<input type="checkbox"/>	<input type="checkbox"/>	
c. Two	<input type="checkbox"/>	<input type="checkbox"/>	100.838
d. Three	<input type="checkbox"/>	<input type="checkbox"/>	
e. Four or more	<input type="checkbox"/>	<input type="checkbox"/>	

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

100.1474

- a. Anti-inflammatory drugs (e.g. aspirin compounds, 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.)

8. Listed below are comorbidities which have the potential to influence the outcome of this joint replacement surgery. As defined by the accompanying comorbidity dictionary, which of the following does your patient currently have? (check all that apply): 104.216

- |  |                          |   |                          |
|--|--------------------------|---|--------------------------|
| a. None  | <input type="checkbox"/> | m. Peripheral vascular disease (PVD) (arterial, venous)                   | <input type="checkbox"/> |
| b. Congestive heart failure  | <input type="checkbox"/> | n. Sciatica or chronic back problem                                       | <input type="checkbox"/> |
| c. Hypertension  | <input type="checkbox"/> | o. Neuromuscular disease (i.e. peripheral neuropathy, myasthenia gravis)  | <input type="checkbox"/> |
| d. Ischemic heart disease  | <input type="checkbox"/> | p. Cognitive impairment (i.e. dementia, post traumatic brain dysfunction) | <input type="checkbox"/> |
| e. Cerebral vascular accident (CVA)  | <input type="checkbox"/> | q. Hearing impairment   | <input type="checkbox"/> |
| f. Chronic lung disease (including asthma, bronchitis, COPD, or emphysema) | <input type="checkbox"/> | r. Mental illness   | <input type="checkbox"/> |
| g. Renal disease   | <input type="checkbox"/> | s. Substance abuse (including ETOH)                                       | <input type="checkbox"/> |
| h. Hepatic disease   | <input type="checkbox"/> | t. Malignancies (excluding basal cell carcinomas of the skin)             | <input type="checkbox"/> |
| i. Gastro-intestinal disease   | <input type="checkbox"/> | u. Leg ulcers   | <input type="checkbox"/> |
| j. Arthritis (in areas other than the knee)                                | <input type="checkbox"/> | v. Bleeding disorders   | <input type="checkbox"/> |
| k. Non-insulin-dependent diabetes mellitus (NIDDM)                         | <input type="checkbox"/> |   |                          |
| l. Insulin-dependent diabetes mellitus (IDDM)                              | <input type="checkbox"/> |   |                          |

9. SOURCES OF INFECTION that could influence outcome of joint replacement (check all that apply):

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

100.314

10. OTHER DISABLING JOINT DISEASE that could affect the outcomes of joint replacement (check all that apply):

	Right	Left		
a. Upper extremity	<input type="checkbox"/>	<input type="checkbox"/>	d. Back	<input type="checkbox"/> 100.805
b. Hip	<input type="checkbox"/>	<input type="checkbox"/>	e. Other	<input type="checkbox"/>
c. Knee	<input type="checkbox"/>	<input type="checkbox"/>		

11. PRE-OPERATIVE INTRA-ARTICULAR INFECTION (check one for each column):

	Right	Left	
a. No prior infection	<input type="checkbox"/>	<input type="checkbox"/>	100.1295
b. Prior infection, now resolved	<input type="checkbox"/>	<input type="checkbox"/>	

12. DEGREE OF LIMP (check only one for each row): 104.217

	None	Slight	Moderate	Severe	Unable to Walk	N/A
a. Without support	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>

13. RADIOLOGICAL EVIDENCE OF ARTHRITIS OF KNEE (weight bearing film) (check one for each column and knee): 104.218

	Patello-Femoral Compartment	Medial Compartment	Lateral Compartment
<b>13a. RIGHT KNEE</b>			
a. None (no abnormality)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Minimal—e.g. osteophytes only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Moderate—less than or equal to 50% joint space narrowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Severe—greater than 50% joint space narrowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Not assessed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>13b. LEFT KNEE</b>			
a. None (no abnormality)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Minimal—e.g. osteophytes only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Moderate—less than or equal to 50% joint space narrowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Severe—greater than 50% joint space narrowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Not assessed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. 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"/>

15. 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"/>

16. 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"/>

17. KNEE MEDIOLATERAL WEIGHT BEARING ALIGNMENT (degrees) (standing) 104.219  
(check one for each row):

	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"/>

18. 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"/>

19. 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"/>