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NEW KNEE PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: ______________________________ Date of visit: ______________

Date of Birth (DD/MM/YYYY): ______________ Age: ______ Marital Status: ______________

Home Address: ____

____

Home phone number: ______________ Mobile Number: ______________ Male ☐ Female ☐

Family Doctor Name and Address: ____

____

Medical Insurance: ☐ VHI ☐ Aviva ☐ Laya ☐ Glo Healthcare ☐ Garda ☐ ESB ☐ POMA ☐ Self-Pay

Plan type: ______________ Policy Number: ______________

Who referred you? ____

What is your main problem today? ____

____

____

When did your symptoms begin? ____

Are your symptoms the result of an injury? ☐ Yes ☐ No

If yes, what happened? ____

____

Is there litigation pending as a result of your pain/injury? ☐ Yes ☐ No

Have you been treated by anyone for this problem? ☐ Yes ☐ No If yes, by whom: ______________

What investigations have you had to date: ☐ X-rays ☐ MRI ☐ CT ☐ Isotope Bone Scan ☐ PET ☐ Ultrasound

Have you had any treatment to date? ☐ Yes ☐ No If yes: ☐ Medication ☐ Physio ☐ Injections

MEDICAL HISTORY:

Have you ***EVER IN YOUR LIFE*** had any of the following problems?

Tick Box ***ONLY i***f you have a history of the conditions below:

HEART PROBLEMS:

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Valve Disease
- ☐ Heart Failure, Heart Attack, Heart Surgery
- ☐ Angiogram, Angioplasty (Stenting)

LUNG PROBLEMS:

- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sleep Apnoea

ENDOCRINE PROBLEMS:

- ☐ Diabetes
- ☐ Thyroid - Hyperthyroidism
- ☐ Thyroid - Hypothyroidism

BLADDER OR KIDNEY PROBLEMS:

- ☐ Difficulty passing urine
- ☐ Urinary tract infections
- ☐ Frequency/Urgency

STOMACH OR BOWEL PROBLEMS:

- ☐ Ulcers
- ☐ Diverticulitis
- ☐ Crohn's Disease/Ulcerative Colitis

GENERAL:

- ☐ Previous Clots – Lung or Leg
- ☐ Epilepsy

CANCER:

- ☐ No
- ☐ Yes What kind

ARE YOU ALLERGIC TO ANY MEDICATION?

- ☐ No
- ☐ Yes What happens:

PLEASE LIST ANY **MEDICATION** THAT YOU ARE TAKING NOW (or attach a list):

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

BLOOD THINING MEDICATION:

Are you taking any of the following medications:

Pradaxa ☐ Xarelto ☐ Plavix ☐ Warfarin ☐ Aspirin ☐

SURGICAL HISTORY

Please list any surgeries that you have had in the past:

SURGERY	SURGEON	LOCATION	DATE
1			
2			
3			
4			
5			
6			
7			

SOCIAL HISTORY

Do you smoke now? ☐ Yes ☐ No

If Yes, how much? ☐ 5/Day ☐ 10/Day ☐ 20/Day ☐ More For How Long? _______________

If No, Did you ever smoke? ☐ Yes ☐ No If Yes, When did you stop? ____________________

How much did you smoke? ☐ 5/Day ☐ 10/Day ☐ 20/Day ☐ More For How Long? _______________

Do you drink alcohol? ☐ Yes ☐ No If Yes, how much in a week? ___________________________

What is your occupation? ____

Where do you live:

☐ House ☐ Apartment ☐ Nursing Home ☐ Assisted living

With whom do you live? ____

FAMILY HISTORY?

Does anyone in your family have a history of arthritis? ____

If so, have they had joint replacement surgery, and what kind? _______________________________________

Are your parents deceased? ☐ Yes ☐ No

If so how did they die:

Mother: Cause: ____ Age ________

Father Cause: ____ Age ________

What is your: HEIGHT? WEIGHT?

PERSON TO CONTACT IN AN EMERGENCY?

NAME: ____ TEL: ____________________________

NAME: ____ TEL: ____________________________

Oxford Knee Score

Please answer every question by placing a ***tick on the response that best describes your condition today.***

1. How would you describe the pain you usually have in your knee?		**7. Could you kneel down and get up again afterwards?**	
None		Yes, Easily	
Very mild		With little difficulty	
Mild		With moderate difficulty	
Moderate		With extreme difficulty	
Severe		No, impossible	
2. Have you had any trouble with washing and drying yourself (all over) because of your knee?		**8. Are you troubled by pain in your knee at night in bed?**	
No trouble at all		Not at all	
Very little trouble		Only one or two nights	
Moderate trouble		Some nights	
Extreme difficulty		Most nights	
Impossible to do		Every night	
3. Have you had any trouble getting in and out of the car or using public transport because of your knee?		**9. How much has the pain from your knee interfered with your usual work (including housework)?**	
No trouble at all		Not at all	
Very little trouble		A little bit	
Moderate trouble		Moderately	
Extreme difficulty		Greatly	
Impossible to do		Totally	
4. For how long have you been able to walk before the pain in your knee becomes severe (with or without a walking aid)?		**10. Have you felt that your knee might suddenly give way or let you down?**	
No pain >60min		Rarely/Never	
16-60 minutes		Sometimes or just at first	
5-15 minutes		Often, not just at first	
Around the house only		Most of the time	
Not at all-severe on walking		All the time	
5. After a meal (sat at a table), how painful has it been when you stand up from a chair because of your knee?		**11. Could you do the household shopping on your own?**	
Not at all painful		Yes easily	
Slightly painful		With little difficulty	
Moderately Painful		With Moderate difficulty	
Very Painful		With Extreme difficulty	
Unbearable		Impossible to do	
6. Have you been limping when walking because of your knee?		**12. Could you walk down a flight of stairs?**	
Rarely/never		Yes easily	
Sometimes or just at first		With little difficulty	
Often, not just at first		With moderate difficulty	
Most of the time		With extreme difficulty	
All of the time		No, impossible	

For Surgeon Use Only

Knee Range of Motion:

Knee ROM	Active		Passive	
	L	R	L	R
Flexion				
Extension				
Lag				
Effusion				
Tenderness				
Erythema				

Hip ROM		
	L	R
Flexion (110°)		
Extension (30°)		
Abduction (40°)		
Adduction (40°)		
IR Flex (40°)		
ER Flex (50°)		

Gait: Normal ☐ Antalgic ☐ Flexed Knee ☐ Short Leg ☐ Other__________

Knee Stability **AP** **›5mm** ☐ **5-10** ☐ **›10 mm** ☐ Lachmann -Ve ☐ +1Ve ☐ +2Ve ☐ +3Ve ☐

ML **›5mm** ☐ **5-10** ☐ **›10 mm** ☐ Pivot Shift Yes ☐ No ☐

Rot. Instability Alignment Yes ☐ No ☐

Non-Weight bearing Alignment Neutral ☐ Varus ☐ Valgus ☐

Standing/Stress Alignment Neutral ☐ Varus ☐ Valgus ☐

Prior incision: Yes ☐ No ☐ If yes, where? _________________

Tender: Yes ☐ No ☐ If yes, where? _________________

Neurovascular:

Sensation : Intact ☐ Abnormal ☐ If yes, where? _________________

Previous Surgery:

Date:

Arthroscopy L ☐ R ☐

Previous TKR L ☐ R ☐

Motor:

Right Motor	Left Motor:
EHL_________	EHL________
TA _________	TA_________
QUAD ______	QUAD_______

Pulses: DP ☐ PT ☐ DP ☐ PT ☐

XR Analysis:

DX: OA ☐ RA ☐ AVN ☐ Post Trauma ☐ Post Infection ☐ Previous Osteotomy ☐ Other: ________

X-RAY LOCATION& DATE:

MRI LOCATION & DATE: