HSS CJRC
HOSPITAL FOR SPECIAL SURGERY

CJRC USE ONLY:
Time Point: Pre-Op, 6 Week, 1 Year, 2 Year, 5 Year

Patient Follow-Up Questionnaire

Complex Joint Reconstruction Center

Please print your patient information:

First Name _____ M.I. _____ Last Name _____

Date of Birth _____ Today's Date _____

E-mail _____

Please select which joint(s) will be or has been replaced:

Location/Laterality

Hip	Left	Right	Both
Knee	Left	Right	Both

Please complete the additional pages to the best of your ability. Thank you.

Please select your Surgeon:

☐ Dr. Alexiades	☐ Dr. Cornell	☐ Dr. Haas	☐ Dr. McLawhorn	☐ Dr. Pellicci	☐ Dr. T Sculco
☐ Dr. Boettner	☐ Dr. Cross	☐ Dr. Jerabek	☐ Dr. Padgett	☐ Dr. A Ranawat	☐ Dr. Su
☐ Dr. Bostrom	☐ Dr. Della Valle	☐ Dr. Lyden	☐ Dr. Parks	☐ Dr. C Ranawat	☐ Dr. Westrich
☐ Dr. Buly	☐ Dr. Figgie	☐ Dr. Mayman	☐ Dr. Pearle	☐ Dr. P Sculco	☐ Dr. Windsor

VR-12 Health Survey

Instructions: These questions ask for your views about your health. Answer every question by marking the box. If you are unsure how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor

2. The following questions are about activities you might do during a typical day. Does **your health now limit** you in these activities? If so, how much?
   a. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?

Yes, limited a lot	Yes, limited a little	No, not limited at all

   b. Climbing **several** flights of stairs?

Yes, limited a lot	Yes, limited a little	No, not limited at all

3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?
   a. Accomplished **less** than you would like.

None of the time	A little of the time	Some of the time	Most of the time	All of the time

   b. Were limited in the **kind** of work or other activities.

None of the time	A little of the time	Some of the time	Most of the time	All of the time

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?
   a. **Accomplished less** than you would like.

None of the time	A little of the time	Some of the time	Most of the time	All of the time

   b. Didn't do work or other activities as **carefully** as usual.

None of the time	A little of the time	Some of the time	Most of the time	All of the time

5. During the past 4 weeks, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely

6a. How much of the time during the past 4 weeks: have you felt calm and peaceful?

All of the time	Most of the time	Good bit of the time	Some of the time	Little of the time	None of the time

6b. How much of the time during the past 4 weeks: did you have a lot of energy?

All of the time	Most of the time	Good bit of the time	Some of the time	Little of the time	None of the time

6c. How much of the time during the past 4 weeks: have you felt downhearted and blue?

All of the time	Most of the time	Good bit of the time	Some of the time	Little of the time	None of the time

7. During the past 4 weeks, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time

8. Compared to one year ago, how would you rate your **physical health** in general now?

Much better	Slightly better	About the same	Slightly worse	Much worse

9. Compared to one year ago, how would you rate your **emotional problems** (such as feeling anxious, depressed, or irritable) **now**?

Much better	Slightly better	About the same	Slightly worse	Much worse

Name: _____

HOOS, JR. Hip Survey (skip if you are seeing the surgeon about your Knee)

Instructions: This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.
Answer every question by ticking the appropriate box (only one box for each question). If you are unsure about how to answer a question, please give the best answer you can.

Which Hip:	Left	Right	Both

Pain: What amount of hip pain have you experienced the last week during the following activities?

1. Going up or down stairs:

None	Mild	Moderate	Severe	Extreme

2. Walking on an uneven surface:

None	Mild	Moderate	Severe	Extreme

Function, daily living: The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the last week due to your hip.

3. Rising from sitting:

None	Mild	Moderate	Severe	Extreme

4. Bending to floor/pick up an object:

None	Mild	Moderate	Severe	Extreme

5. Lying in bed (turning over, maintaining hip position):

None	Mild	Moderate	Severe	Extreme

6. Sitting:

None	Mild	Moderate	Severe	Extreme

Name: _____

KOOS, JR. Knee Survey (skip if you are seeing the surgeon about your Hip)

Instructions: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to do your usual activities.
Answer every question by ticking the appropriate box (only one box for each question). If you are unsure about how to answer a question, please give the best answer you can.

Which Knee:	Left	Right	Both

Stiffness: Amount of joint stiffness you have experienced the last week in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?

None	Mild	Moderate	Severe	Extreme

Pain: What amount of knee pain have you experienced in the last week during the following activities?

2. Twisting/pivoting on your knee:

None	Mild	Moderate	Severe	Extreme

3. Straightening knee fully:

None	Mild	Moderate	Severe	Extreme

4. Going up or down stairs:

None	Mild	Moderate	Severe	Extreme

5. Standing upright:

None	Mild	Moderate	Severe	Extreme

Function, daily living: The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the last week due to your knee.

6. Rising from sitting:

None	Mild	Moderate	Severe	Extreme

7. Bending to floor/pick up an object:

None	Mild	Moderate	Severe	Extreme

Name: _____

LOWER EXTREMITY ACTIVITY SCALE

***Instructions**: Please read through each description given below; pick **ONE** description that best describes your regular daily activity and put a check in that box (only one box).*

CHECK ONLY ONE (1) BOX ON THIS PAGE

☐ 1. I am confined to bed all day. (1)

☐ 2. I am confined to bed most of the day except for minimal transfer activities (going to the bathroom, etc.). (2)

☐ 3. I am either in bed or sitting in a chair most of the day. (3)

☐ 4. I sit most of the day, except for minimal transfer activities, no walking or standing. (4)

☐ 5. I sit most of the day, but I stand occasionally and walk a minimal amount in my house. (I may rarely leave the house for an appointment and may require the use of a wheelchair or scooter for transportation). (5)

☐ 6. I walk around my house to a moderate degree but I don't leave the house on a regular basis. I may leave the house occasionally for an appointment. (6)

☐ 7. I walk around my house and go outside at will, walking one or two blocks at a time. (7)

☐ 8. I walk around my house, go outside at will and walk several blocks at a time without any assistance (weather permitting). (8)

☐ 9. I am up and about at will in my house and can go out and walk as much as I would like with no restrictions (weather permitting). (9)

10. I am up and about at will in my house and outside. I also work outside the house in a:
    - ☐ minimally (10)
    - ☐ moderately (11)
    - ☐ extremely active job (12)

11. I am up and about at will in my house and outside. I also participate in relaxed physical activity such as jogging, dancing, cycling, swimming:
    - ☐ occasionally (2-3 times per month) (13)
    - ☐ 2-3 times per week (14)
    - ☐ daily (15)

12. I am up and about at will in my house and outside. I also participate in vigorous physical activity such as competitive level sports:
    - ☐ occasionally (2-3 times per month) (16)
    - ☐ 2-3 times per week (17)
    - ☐ daily (18)

Name: _____

PAIN SCALE

Current Pain Level (no pain 0 – 10 highest):

While Walking

0	1	2	3	4	5	6	7	8	9	10

While negotiating stairs

0	1	2	3	4	5	6	7	8	9	10

At rest (sitting, lying down, sleeping)

0	1	2	3	4	5	6	7	8	9	10

Name: _____