



Total Knee Arthroplasty Preoperative Patient Self-Assessment

Patient Name: _____ Patient Date of Birth: _____

Date: _____

Please respond to each question or statement by marking one box per row.

How comfortable are you filling out medical forms by yourself?	<input type="checkbox"/> Not at all <input type="checkbox"/> A little bit <input type="checkbox"/> Somewhat <input type="checkbox"/> Quite a bit <input type="checkbox"/> Extremely
Have you used narcotics, including prescription pain medication, for more than 90 days?	<input type="checkbox"/> No, less than 90 days/never <input type="checkbox"/> Yes, over 90 days
What amount of pain have you experienced in the last week in your other knee/hip?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
My back pain at the moment is:	<input type="checkbox"/> None <input type="checkbox"/> Very mild <input type="checkbox"/> Moderate <input type="checkbox"/> Fairly severe <input type="checkbox"/> Very severe <input type="checkbox"/> Extreme
In the last week, how severe is your knee stiffness after first wakening in the morning?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
In the last week, what amount of knee pain have you experienced during twisting or pivoting on your knee?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
In the last week, what amount of knee pain have you experienced when straightening your knee fully?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
In the last week, what amount of knee pain have you experienced when going up or down stairs?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
In the last week, what amount of knee pain have you experienced when standing upright?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
In the last week, what degree of difficulty you have experienced rising from sitting due to your knee?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme
In the last week, what degree of difficulty you have experienced bending to the floor/picking an object up due to your knee?	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extreme

During the past 4 weeks, have you accomplished less in work or other daily activities than you would like as a result of any emotional problems (such as feeling depressed or anxious)?	<input type="checkbox"/> No, none of the time	<input type="checkbox"/> Yes, a little of the time	<input type="checkbox"/> Yes, some of the time	<input type="checkbox"/> Yes, most of the time	<input type="checkbox"/> Yes, all of the time	
During the past 4 weeks, did you not do work or other activities as carefully as usual as a result of any emotional problems (such as feeling depressed or anxious)?	<input type="checkbox"/> No, none of the time	<input type="checkbox"/> Yes, a little of the time	<input type="checkbox"/> Yes, some of the time	<input type="checkbox"/> Yes, most of the time	<input type="checkbox"/> Yes, all of the time	
How much of the time during the past 4 weeks have you felt calm and peaceful?	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> A good bit of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> A little of the time	<input type="checkbox"/> None of the time
How much of the time during the past 4 weeks have you had a lot of energy?	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> A good bit of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> A little of the time	<input type="checkbox"/> None of the time
How much of the time during the past 4 weeks have you felt downhearted and blue?	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> A good bit of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> A little of the time	<input type="checkbox"/> None of the time
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.)?	<input type="checkbox"/> All of the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Some of the time	<input type="checkbox"/> A little of the time	<input type="checkbox"/> None of the time	
In general, would you say your quality of life is:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Good	<input type="checkbox"/> Very Good	<input type="checkbox"/> Excellent	
In general, how would you rate your mental health, including your mood and your ability to think?	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Good	<input type="checkbox"/> Very Good	<input type="checkbox"/> Excellent	
In general, how would you rate your satisfaction with your social activities and relationships?	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Good	<input type="checkbox"/> Very Good	<input type="checkbox"/> Excellent	
In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always	

Thank you for taking the time to participate in our survey.

Patient Signature: _____