

POSM/OFALS KNEE SUBJECTIVE FOLLOW-UP

MEDICAL RECORD #

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NAME: _____

FOLLOWUP PERIOD: 6 month 1 year 2 year 5 year

EXAM DATE:

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AFFECTED KNEE:

PHYSICIAN:

- Right
- Left
- Both Knees

- KP
- EB
- Other

DATE OF SURGERY

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General Information

1. Currently, how does your knee function:

Normal Nearly Normal Abnormal Severely Abnormal

2. During the past 4 weeks or since your re-injury, how often had you had pain?

Never 0 1 2 3 4 5 6 7 8 9 10 Constant

3. If you had pain how severe is it?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

4. How would you rate the function of your knee(s) on a scale of 0 to 10 with 0 being no limitation (normal, excellent function) and 10 being complete inability to perform any of your usual daily activities?

Current function of your knee:

no limitation 0 1 2 3 4 5 6 7 8 9 10 cannot perform daily activities

Prior function of your knee: (before injury or surgery)

no limitation 0 1 2 3 4 5 6 7 8 9 10 cannot perform daily activities

Re-injury and Additional Surgery Information

5. If you had a re-injury requiring medical attention, when did the injury occur?

Date: _____ Not applicable

How did the reinjury occur (*check as many as apply*)?

- | | |
|--|---|
| <input type="radio"/> No specific injury | <input type="radio"/> Participating in a RECREATIONAL Sport |
| <input type="radio"/> Auto Accident | <input type="radio"/> Participating in a SERIOUS RECREATIONAL/COMPETITIVE Sport |
| <input type="radio"/> Slip and/or Fall | <input type="radio"/> Participating in a SCHOLASTIC COMPETITIVE Sport |
| <input type="radio"/> Lifting Activity | <input type="radio"/> Participating in a PROFESSIONAL/WORLD CLASS Sport |
| <input type="radio"/> Blow to the Knee | <input type="radio"/> Jumping Activity |
| <input type="radio"/> Twisted Knee | <input type="radio"/> Other, PLEASE specify: _____ |

6. Since your latest surgery here, have you had any other surgery on your affected knee that was performed elsewhere? Yes No

If so, when? Date:

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Procedure: _____

Sport Participation Information (if applicable)

7. If you participate in sports, are you **currently**: Not Applicable

- | | |
|---|---|
| <input type="radio"/> Not Limited in Sports | <input type="radio"/> Unable to participate in MAJORITY of sports |
| <input type="radio"/> Unable to participate in a FEW sports | <input type="radio"/> Unable to participate in a ALL sports |

8. If you participate in sports, your **current** activity level in sports is: Not applicable

- Sedentary Recreational Serious Recreational/Competitive Scholastic Competitive Professional/World Class

9. Current Sport _____ How often? _____ (days/wk)

Daily Activities Assessment

10. Rate the following on a scale of 1 to 10.

	<u>Worst</u>				<u>Fair</u>				<u>Best</u>	
1) Rate your current ability to perform Activities of Daily Living	1	2	3	4	5	6	7	8	9	10
2) Rate your current ability to perform Strenuous Work	1	2	3	4	5	6	7	8	9	10
3) Rate your current ability to perform Sedentary Work	1	2	3	4	5	6	7	8	9	10

11. Answer the next 2 questions using the following definition:

Very Strenuous=activities like jumping/pivoting like in basketball or soccer. **Strenuous** = activities like heavy physical work, skiing, or tennis. **Moderate** = activities like moderate physical work, running or jogging. **Light** =activities like walking, housework, or yard work

What is the highest level of activity you can perform without significant:

- Knee pain Very Strenuous Strenuous Moderate Light Unable
- Giving way in your knee Very Strenuous Strenuous Moderate Light Unable
- Swelling in your knee Very Strenuous Strenuous Moderate Light Unable

What is the highest level of activity you can participate in on a regular basis?

- Very Strenuous Strenuous Moderate Light Unable

12. How does your knee affect your activity level?

- No Affect Mildly Moderately Severely

13. How does your knee affect your ability to:

	Not Difficult	Minimally Difficult	Moderately Difficult	Extremely Difficult	Unable to do
A) Walking	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
B) Ascending Stairs	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
C) Descending Stairs	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
D) Run straight ahead	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
E) Kneel on front of knee	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
F) Sit with your knee bent	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
G) Rise from a chair	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
H) Stop & start quickly	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
I) Jump & land on involved leg	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

14. Please grade each symptom that you experience currently during your highest level of activity.

Please fill out both knees

	LEFT KNEE				RIGHT KNEE			
	NONE	MILD	MODERATE	SEVERE	NONE	MILD	MODERATE	SEVERE
a) Pain	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
b) Full Giving Way	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
c) Noise Sensations	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4
d) Joint Stiffness	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4

15. Please grade each symptom that you experience currently during your highest level of activity?

Swelling:	<input type="radio"/> None	<input type="radio"/> Mild (on severe exertion)	<input type="radio"/> Moderate (on ordinary exertion)	<input type="radio"/> Severe
Pain:	<input type="radio"/> None	<input type="radio"/> Intermittent and slight during severe exertion	<input type="radio"/> Increased during severe exertion	<input type="radio"/> Increased on or after walking more than 2km <input type="radio"/> Increased on or after walking less than 2km <input type="radio"/> Constant
Crutch Use:	<input type="radio"/> None	<input type="radio"/> 1 Crutch (stick or crutch)	<input type="radio"/> 2 Crutch (stick or crutch)	<input type="radio"/> Weight bearing impossible
Walking with a limp:	<input type="radio"/> Yes (severe or constant) <input type="radio"/> No (none) <input type="radio"/> Somewhat (slight or periodical) <input type="radio"/> Not applicable			
Locking:	<input type="radio"/> No locking and no catching sensations	<input type="radio"/> Locking frequently	<input type="radio"/> Locked Joint	<input type="radio"/> Catching but no locking sensations <input type="radio"/> Locking occasionally <input type="radio"/> Constant
Instability:	<input type="radio"/> Never giving away	<input type="radio"/> Frequently during athletics or other severe exertion	<input type="radio"/> Often in daily activities	<input type="radio"/> Occasionally in daily activities <input type="radio"/> Rarely during athletics or other severe exertion <input type="radio"/> Every step
Stair Climbing:	<input type="radio"/> No problems	<input type="radio"/> Slightly Impaired	<input type="radio"/> One step at a time	<input type="radio"/> Impossible
Squatting:	<input type="radio"/> No problems	<input type="radio"/> Slightly Impaired	<input type="radio"/> Not beyond 90 deg	<input type="radio"/> Impossible

16. Please choose one of the following which best describes your current activity level.

- Level 10 Competitive Sports(Soccer, Football, Rugby (national elite))
- Level 9 Competitive Sports(Soccer, Football, Rugby (lower divisions), hockey, wrestling, gymnastics)
- Level 8 Competitive Sports(Racquetball, Squash, Track and Field, Alpine Skiing)
- Level 7 Competitive Sports (Tennis, Athletics(Running), Handball, Basketball, Motorcross, Cross country tr
Recreational Sports (Soccer, Football, Hockey, Squash, Athletics(jumping), Cross country track)
- Level 6 Recreational Sports (Tennis, Handball, Basketball, Alpine skiing, Jogging 5X/week)
- Level 5 Work (Heavy Labor)
Competitive Sports (Cycling, X-country Skiing) Recreational (Jogging on uneven ground 2x/week)
- Level 4 Work (Moderately Heavy Labor (truck driving, etc)
Recreational Sports (Cycling, Cross Country Skiing, Jogging on even ground 2X/week)
- Level 3 Work (Light Labor)
Comp & Rec Sports (Swimming), Hiking, Backpacking
- Level 2 Work (Light Labor)
Walking on uneven ground possible but impossible to backpack or hike
- Level 1 Work(light labor)
Walking on even ground possible
- Level 0 Sick leave or disability pension because of knee problems

17. From the above scale, what is your **desired acitivity level?**

- Level_1 Level_2 Level_3 Level_4 Level_5 Level_6 Level_7 Level_8 Level_9 Level_10

HSS KNEE SURVEY	<u>Pain (30 points)</u>	<u>Walking (12 points)</u>	<u>Transfer activities (5 points)</u>
	<input type="checkbox"/> Not at any time (30)	<input type="checkbox"/> Walking / standing unlimited (12)	<input type="checkbox"/> No support (5)
	<input type="checkbox"/> Not when walking(15)	<input type="checkbox"/> 5-10 blocks, stand < 1/2 hour (10)	<input type="checkbox"/> Req. support (2)
	<input type="checkbox"/> Mild when walking(10)	<input type="checkbox"/> 1-5 blocks, stand < 1/2 hour (8)	<u>Locking (15 points)</u>
<input type="checkbox"/> Moderate when walking (5)	<input type="checkbox"/> Walk <1 block (4)	<input type="checkbox"/> No lock / catch (15)	
<input type="checkbox"/> Severe when walking (0)	<input type="checkbox"/> Can't walk (0)	<input type="checkbox"/> Catch, no lock (10)	
<input type="checkbox"/> None at rest (15)		<input type="checkbox"/> Locking occas. (6)	
<input type="checkbox"/> Mild at rest (10)	<u>Stairs (5 points)</u>	<input type="checkbox"/> Locking freq. (2)	
<input type="checkbox"/> Moderate at rest (5)	<input type="checkbox"/> Climbing stairs (5)	<input type="checkbox"/> Lock on exam.(0)	
<input type="checkbox"/> Severe at rest (0)	<input type="checkbox"/> Climbing w/ support (2)		
<u>Crutches (-3 points)</u>			
<input type="checkbox"/> None (0)			
<input type="checkbox"/> 1 cane (-1)			
<input type="checkbox"/> 1 crutch (-2)			
<input type="checkbox"/> 2 crutches (-3)			
		TABLE 1 TOTAL	

Flexion deformity (10 points)
 None (10)
 Few degrees (8)
 5 - 10 degrees (5)
 > 11 degrees (0)

Alignment
 _____ varus
 _____ valgus
 Each 5 deg. varus / valgus (-1)

Extension Lag (-5 points)
 0 degrees (0)
 5 degrees (-2)
 10 degrees (-3)
 15 degrees (-5)

ROM (18 points)
 _____ to _____
 (8 degrees = 1 point)
 _____ deg/8 = _____

Muscle strength (10 points)
 Good - no break quad (10)
 Good - can break quad (8)
 Fair - moves through arc (4)
 Poor - can't move through arc (0)

Instability (10 points)
 None (10)
 Mild, 0-5 degrees (8)
 Moderate, 6-15 degrees (5)
 Severe, >16 deg. (0)

_____ **TABLE 2 TOTAL**

Lysholm Total: _____ Tegner Level: _____ HSS: _____

Rehab Assessment

18. Currently, what is your rehabilitation program that you have been using (check as many as apply)?

- 1 Home therapy program prescribed by your Doctor (i.e. Sport Cord / Body Lines, cycling, aquajogger, swimming, ect.)
- 2 I see a Physical Therapist frequently (2 times a week or more)
- 3 I see a Physical Therapist occasionally (Once a week or less)
- 4 None
- 5 Other _____

19. Currently, what other type of activities have you been doing for rehabilitation?

- | | | | | |
|-------------------------------------|--------------------------------------|---------------------------------------|--|-----------------------------------|
| <input type="radio"/> Stretching | <input type="radio"/> Weight Lifting | <input type="radio"/> Aerobics | <input type="radio"/> Bike Outside (Road or Mtn) | <input type="radio"/> Skiing |
| <input type="radio"/> Pool Workouts | <input type="radio"/> Squats | <input type="radio"/> Stationary Bike | <input type="radio"/> Running | <input type="radio"/> Skating |
| <input type="radio"/> Cybex | <input type="radio"/> Lunges | <input type="radio"/> Stair Stepper | <input type="radio"/> Jogging | <input type="radio"/> Tennis |
| <input type="radio"/> ROM Exercises | <input type="radio"/> Leg lifts | <input type="radio"/> Treadmill | <input type="radio"/> Hiking | <input type="radio"/> Golf |
| <input type="radio"/> Pilates | <input type="radio"/> Plyometrics | <input type="radio"/> Rowing Machine | <input type="radio"/> Walking | <input type="radio"/> Other _____ |
| <input type="radio"/> Yoga | <input type="radio"/> Manual Labor | <input type="radio"/> Swimming | | |

20. Currently, are you back to your original fitness program? NA Yes No Somewhat

Rate the following on a scale from 1 to 10.

Very Satisfied	Neutral	Very Unsatisfied
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21. How satisfied are you with your **MEDICAL** treatment at Plancher Orthopedics and Sports Medicine? 10 9 8 7 6 5 4 3 2 1

22. How satisfied are you with your **current OUTCOME**? 10 9 8 7 6 5 4 3 2 1

Would you have an injection again? No Yes

Would you have surgery again? No Yes

Would you recommend your treatment to a relative or close friend with the same problem? No Yes