Joint Replacement and Spine Surgery Patient Questionnaire

Please bring this completed questionnaire with you to your preoperative class.

Patient History:

Name: _________________________________ Date of Birth: _______________

Height: _______________ Weight: _______________ Age: _______________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Occupation/Retired: __________________________________________

Social Situation:

Who do you live with: ☐ Alone ☐ Spouse/family ☐ Caregiver (___ hrs/day) ☐ Other________

☐ Single story house, ________ steps to enter

☐ Two story house, ________ steps to enter. Bed/bathroom located on ________ floor.

☐ Apartment on ____________floor. Elevator available? ☐ Yes ☐ No

☐ Other: ______________________

History of Present Illness:

Surgical Procedure: ☐ Spine Surgery ☐ Lumbar ☐ Thoracic ☐ Cervical

☐ Knee replacement ☐ Left ☐ Right

☐ Hip replacement ☐ Left ☐ Right

Anterior Approach ☐ Posterior Approach

Date and time of surgery: ________________ Surgeon: ____________________________

Do you use an assistive device to walk? ☐ No ☐ Yes List Device(s): ______________________

Are you able to negotiate stairs/curbs? ☐ No ☐ Yes Number Of steps ______________________

List any activity that is limited by or difficult to perform due to joint pain/stiffness:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
Equipment: (Please indicate if you own the following equipment)

Assistive devices:

☐ Front wheeled walker  ☐ Four wheeled walker (with seat)  ☐ Cane
☐ Crutches  ☐ Wheelchair

Adaptive equipment:

☐ Reacher  ☐ Dressing stick  ☐ Sock-aide
☐ Long handled sponge  ☐ Leg lifter  ☐ Long handled shoe horn

Bathroom:

☐ Bedside Commode  ☐ Tub shower combo  ☐ Raised toilet seat
☐ Tub only  ☐ Stall shower  ☐ Tub transfer bench
☐ Hand held shower  ☐ Shower chairs/stool  ☐ Grab bars

Home Assistance: Do you currently require any assistance for the following activities?

☐ Bathing/dressing  ☐ Shopping  ☐ Cooking
☐ Driving  ☐ Housekeeping

Who currently provides you with assist at home, if needed? ________________________________

Following your surgery, are you able to arrange for family/friends to assist you at home? ☐ Yes  ☐ No

What is your intended discharge destination? ____________________________________________

What is your goal for rehabilitation?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Today’s Date: ________________  Therapist: ________________