Patient-Reported Outcome (PRO) Data

North Kansas City Hospital understands that deciding to have a total hip or total knee procedure can be a life changing decision. We collect information, reported by you, that assesses your overall functioning from a mental, emotional and physical perspective. This patient-reported outcome (PRO) data is collected both prior to surgery and again about a year afterward. PRO data helps drive care improvement and demonstrates your progression towards improved function, improved pain and quality of life.

PATIENT DEMOGRAPHIC INFORMATION

Name:

Today's Date:

Sex:
☐ Male
☐ Female

Date of Birth: Enter dates as: (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Medicare Health Insurance Claim Number: ☐ N/A

Height (ft' in") ☐ ☐☐

Weight (lbs.) ☐☐☐

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

How comfortable are you filling out medical forms by yourself?
☐ Extremely ☐ Quite a bit ☐ Somewhat ☐ A little bit ☐ Not at all

SYMPTOMS

What amount of pain have you experienced in the last week in your other knee/hip?
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

My BACK PAIN at the moment is:
☐ None ☐ Very mild ☐ Moderate ☐ Fairly severe ☐ Very severe ☐ Worst imaginable

HEALTH SELF-ASSESSMENT

Please respond to each item by marking one box per row.	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
In general, would you say your quality of life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

In the past 7 days	Never	Rarely	Sometimes	Often	Always
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
How would you rate your fatigue on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

How would you rate your pain on average?	☐ 0 No Pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 Worst imaginable pain

PLEASE TURN OVER TO CONTINUE SURVEY ON BACK

SELF-ASSESSMENT - HIP SURGERY PATIENTS ONLY

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 checking 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.

PAIN

What amount of hip pain have you experienced in the **last week** during the following activities?

1. Going up or down stairs
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Extreme

2. Walking on an uneven surface
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-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
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Extreme

4. Bending to floor/pick up an object
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Extreme

5. Lying in bed (turning over, maintaining hip position)
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Extreme

6. Sitting
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Extreme

SELF-ASSESSMENT - KNEE SURGERY PATIENTS ONLY

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 checking 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.

STIFFNESS

The following question concerns the amount of joint stiffness you have experienced during 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 when you first wake up in the morning?
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Extreme

PAIN

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

2. Twisting/pivoting on your knee
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Extreme

3. Straightening knee fully
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Extreme

4. Going up or down stairs
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Extreme

5. Standing upright
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-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
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Extreme

7. Bending to floor/pick up an object
☐ 0-None ☐ 1-Mild ☐ 2-Moderate ☐ 3-Severe ☐ 4-Extreme

PLEASE COMPLETE THE ENTIRE SURVEY AND RETURN IN THE ENCLOSED ENVELOPE