★★★ **Are you currently receiving ANY home health services? ❑ YES ❑ NO**

Name: _____ Age:_____ Today's Date: _____

What joint are you having replaced? ☐ Hip ☐ Knee ☐ Left side ☐ Right side **Surgery Date:** _____

Have you had a previous total joint replacement? ☐ No ☐ Yes ➔ Which joint and when? _____

What is your goal after you receive a total joint replacement? _____

Home Environment

Do you live: ☐ Alone ☐ With others

How many stairs do you have to get into your home from outside? _____ Is there a railing? ☐ Yes ☐ No

Do you have to climb stairs to get to: Bedroom? ☐ No ☐ Yes ➔ How many? _____ Railing? ☐ Yes ☐ No

Bathroom? ☐ No ☐ Yes ➔ How many? _____ Railing? ☐ Yes ☐ No

Laundry? ☐ No ☐ Yes ➔ How many? _____ Railing? ☐ Yes ☐ No

In your bathroom, do you have: ☐ Tub ☐ Walk-In Shower

Is your bathroom equipped with any special equipment? ☐ Grab bars in tub/shower ☐ Bath/Shower seat or bench

☐ Grab bars by toilet ☐ Raised toilet seat

☐ None ☐ Other: _____

Do you have any of the following in your home? ☐ Throw rugs ☐ Pets ☐ Small Children

Current Functional Level

Have you had any falls in the last year? ☐ No ☐ Yes ➔ Please explain: _____

Are you currently either working, volunteering, or providing caregiving duties? ☐ No ☐ Yes ➔ _____

Are you able to do the following:

☐ Dressing activities:	☐ By myself	☐ With assistance	☐ Stair climbing:	☐ By myself	☐ With assistance
☐ Bathing:	☐ By myself	☐ With assistance	☐ Household chores:	☐ By myself	☐ With assistance
☐ Toilet hygiene:	☐ By myself	☐ With assistance	☐ Driving:	☐ By myself	☐ With assistance
☐ Cooking:	☐ By myself	☐ With assistance	☐ Grocery shopping:	☐ By myself	☐ With assistance

Who will be assisting you with daily activities (dressing, bathing, mobility, driving, etc.) after surgery & for how long?

_____

Mobility / Walking

Approximately how long or how far can you walk before needing to rest? _____

Do you use or need an assistive device to walk, such as a cane or walker? ☐ No ☐ Yes at home ☐ Yes in the community

What device(s) do you use? _____

Do you use assistive devices for any other activities, such as a reacher, sock aid, etc.? ☐ No ☐ Yes

If yes, please describe: _____

Are you currently receiving any community support services, such as Meals on Wheels, etc.? ☐ No ☐ Yes

If yes, please describe: _____

Name three (3) barriers you perceive may limit your ability to return home after surgery?

1. _____
2. _____
3. _____

Past Medical History: Do you have ANY previous history of the things listed below?

CONDITIONS:	YES	NO	CONDITIONS:	YES	NO
High Blood Pressure			Pacemaker		
Heart Condition			Seizures		
Stroke(s)			Cancer		
Metal Implants			Shortness of Breath		
Diabetes			Asthma		
Dizziness			Persistent Night Pain		
Dizziness or Light Headedness			Frequent/Severe Headaches		
Excessive Fatigue			**Unexplained** Weight Loss		
Broken Bones (fractures)			Past or Current Bowel/Bladder dysfunction		
Fibromyalgia			Gynecological Issues		
Arthritis			Vaginal/Cesarean Birth (Number: _____)		
Thyroid Problems			↳ Did you have any back pain with your pregnancy or after childbirth?		
Kidney Problems					
Blood Clots and/or Poor Circulation			Other:		

Staff Initials	Date	Time	ALLERGIES Do you have any allergies? ☐ No ☐ Yes, please list:	REACTION(S)

Staff Initials	Date	Time	OTHER DIAGNOSES AND/OR SIGNIFICANT CONDITIONS Do you have any other diagnoses &/or significant conditions? ☐ No ☐ Yes, please list:

Staff Initials	Date	Time	PREVIOUS PROCEDURES / SURGERIES Do you have any previous procedures or surgeries? ☐ No ☐ Yes, please list:

Staff Initials	Date	Time	CURRENT MEDICATIONS ☐ See attached list of medications that the patient provided. Are you currently taking any medications, including herbals? ☐ No ☐ Yes, please list:

INITIALS	STAFF SIGNATURE	INITIALS	STAFF SIGNATURE

TIME: _____ DATE: _____ PATIENT SIGNATURE: _____

PLACE PATIENT LABEL HERE