

Evaluator Name _____ Date _____

Patient Name/Number _____ Pre-op _____ Post-op _____

Surgeon Name _____ Hospital Number _____

X-ray Date _____ Prior Implants _____

Left Knee Right Knee Recumbent Standing

AP

Femoral Flexion (a) _____
 Tibial Angle (b) _____
 Total Valgus Angle(a+b) _____

18" Film _____
 3' Film _____

LAT

Femoral Flexion (γ) ⁺ _____
 Tibial Angle (σ) _____

1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____

Total

Med. Lat.

1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____

Total

Ant. Post.

1. _____
 2. _____
 3. _____

Total

Med. Lat.

OR

1. _____
 2. _____
 3. _____
 4. _____
 5. _____

Total

A **B** **C** **D**

Patellar Width (w) _____
 Patellar Tilt (α) _____
 Patellar Tilt P.O. (γ) _____
 Patellar Thickness (T) _____
 Prosthesis-Bone Angle (β) _____
 Patellar Displacement Medial (d) _____
 Patellar Displacement Lateral (d) _____