

KOOS KNEE SURVEY

Today's date: ____/____/____ Date of birth: ____/____/____

Name: _____

INSTRUCTIONS: 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 perform your usual activities.

Answer every question by ticking 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.

Symptoms

These questions should be answered thinking of your knee symptoms during the **last week**.

S1. Do you have swelling in your knee?

Never Rarely Sometimes Often Always

S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?

Never Rarely Sometimes Often Always

S3. Does your knee catch or hang up when moving?

Never Rarely Sometimes Often Always

S4. Can you straighten your knee fully?

Always Often Sometimes Rarely Never

S5. Can you bend your knee fully?

Always Often Sometimes Rarely Never

Stiffness

The following questions concern 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.

S6. How severe is your knee joint stiffness after first wakening in the morning?

None Mild Moderate Severe Extreme

S7. How severe is your knee stiffness after sitting, lying or resting **later in the day**?

None Mild Moderate Severe Extreme

Pain

P1. How often do you experience knee pain?

Never	Monthly	Weekly	Daily	Always
-------	---------	--------	-------	--------

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

P2. Twisting/pivoting on your knee

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

P3. Straightening knee fully

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

P4. Bending knee fully

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

P5. Walking on flat surface

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

P6. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

P7. At night while in bed

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

P8. Sitting or lying

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

P9. Standing upright

None	Mild	Moderate	Severe	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.

A1. Descending stairs

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

A2. Ascending stairs

None	Mild	Moderate	Severe	Extreme
------	------	----------	--------	---------

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A3. Rising from sitting

None Mild Moderate Severe Extreme

A4. Standing

None Mild Moderate Severe Extreme

A5. Bending to floor/pick up an object

None Mild Moderate Severe Extreme

A6. Walking on flat surface

None Mild Moderate Severe Extreme

A7. Getting in/out of car

None Mild Moderate Severe Extreme

A8. Going shopping

None Mild Moderate Severe Extreme

A9. Putting on socks/stockings

None Mild Moderate Severe Extreme

A10. Rising from bed

None Mild Moderate Severe Extreme

A11. Taking off socks/stockings

None Mild Moderate Severe Extreme

A12. Lying in bed (turning over, maintaining knee position)

None Mild Moderate Severe Extreme

A13. Getting in/out of bath

None Mild Moderate Severe Extreme

A14. Sitting

None Mild Moderate Severe Extreme

A15. Getting on/off toilet

None Mild Moderate Severe Extreme

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)
 None Mild Moderate Severe Extreme

A17. Light domestic duties (cooking, dusting, etc)
 None Mild Moderate Severe Extreme

Function, sports and recreational activities

The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your knee.

SP1. Squatting
 None Mild Moderate Severe Extreme

SP2. Running
 None Mild Moderate Severe Extreme

SP3. Jumping
 None Mild Moderate Severe Extreme

SP4. Twisting/pivoting on your injured knee
 None Mild Moderate Severe Extreme

SP5. Kneeling
 None Mild Moderate Severe Extreme

Quality of Life

Q1. How often are you aware of your knee problem?
 Never Monthly Weekly Daily Constantly

Q2. Have you modified your life style to avoid potentially damaging activities to your knee?
 Not at all Mildly Moderately Severely Totally

Q3. How much are you troubled with lack of confidence in your knee?
 Not at all Mildly Moderately Severely Extremely

Q4. In general, how much difficulty do you have with your knee?
 None Mild Moderate Severe Extreme

Thank you very much for completing all the questions in this questionnaire.