

KOOS KNEE SURVEY

Name: _____

Today's date: ____/____/____

Date of Birth: ____/____/____

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
<input type="checkbox"/>				

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

Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>				

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

Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>				

S4. Can you straighten your knee fully?

Always	Often	Sometimes	Rarely	Never
<input type="checkbox"/>				

S5. Can you bend your knee fully?

Always	Often	Sometimes	Rarely	Never
<input type="checkbox"/>				

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
<input type="checkbox"/>				

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

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

Pain

P1. How often do you experience knee pain?

Never	Monthly	Weekly	Daily	Always
<input type="checkbox"/>				

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
<input type="checkbox"/>				

P3. Straightening knee fully

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

P4. Bending knee fully?

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

P5. Walking on flat surface

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

P6. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

P7. At night while in bed

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

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

P8. Sitting or lying

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

P9. Standing upright

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

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
<input type="checkbox"/>				

A2. Ascending stairs

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A3. Rising from sitting

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A4. Standing

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A5. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A6. Walking on flat surface

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A7. Getting in/out of car

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A8. Going shopping

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

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

A9. Putting on socks/stockings

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A10. Rising from bed

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A11. Taking off socks/stockings

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

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

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A13. Getting in/out of bath

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A14. Sitting

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A15. Getting on/off toilet

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

A17. Light domestic duties (cooking, dusting, etc)

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

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 do you have experienced during the **last week** due to your knee.

SP1. Squatting

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

SP2. Running

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

SP3. Jumping

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

SP4. Twisting/pivoting on your injured knee

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

SP5. Kneeling

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

Quality of life

Q1. How often are you aware of your knee problem?

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

Q2. Have you modified your life style to avoid potentially damaging activities?

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

Q3. How much are you troubled with lack of confidence in your knee?

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

Q4. In general, how much difficulty do you have with your knee?

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>				

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