

# 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                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

P3. Straightening knee fully

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

P4. Bending knee fully

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

P5. Walking on flat surface

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

P6. Going up or down stairs

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

P7. At night while in bed

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

P8. Sitting or lying

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

P9. Standing upright

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

A2. Ascending stairs

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

A3. Rising from sitting

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

A4. Standing

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

A5. Bending to floor/pick up an object

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

A6. Walking on flat surface

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

A7. Getting in/out of car

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

A8. Going shopping

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

A9. Putting on socks/stockings

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

A10. Rising from bed

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

A11. Taking off socks/stockings

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

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

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

A13. Getting in/out of bath

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

A14. Sitting

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

A15. Getting on/off toilet

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

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

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

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

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <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 you have experienced during the **last week** due to your knee.

SP1. Squatting

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

SP2. Running

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

SP3. Jumping

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

SP4. Twisting/pivoting on your injured knee

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

SP5. Kneeling

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

### Quality of Life

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

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Never                    | Monthly                  | Weekly                   | Daily                    | Constantly               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all               | Mildly                   | Moderately               | Severely                 | Totally                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

|                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all               | Mildly                   | Moderately               | Severely                 | Extremely                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

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

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