

**KOOS KNEE SURVEY**

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_

**Please rate your pain level with activity:**

0 1 2 3 4 5 6 7 8 9 10  
No Pain Very Severe Pain

**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.