

**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. **If you do not perform these activities - how would it feel if you did?**

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.**