Knee History

Name:____________________________________ Age:__________
Occupation:________________________________

Which Knee is involved: Right Left Both

When did the symptoms first appear: Date:_________

How did symptoms occur: (Check One)

No apparent injury (started slow)
Sports injury: Type of sport:_____________________
Motor vehicle accident Date:___________________
Fall
Unknown

If injured, how did injury occur: (Check all that apply)

Twist
Direct Trauma to the knee
Forced bend to the knee
Force straightening to the knee
Quick stop when leg is in motion

In injured, at time of trauma did you: (Check all that apply)

Hear a pop at the time of the injury
Have immediate swelling within six hours
Develop swelling after six hours

What treatment have you had: (Check all that apply)

X-rays MRI or CAT scan ER Visit
Other physicians, Please list:____________________________________
Medications for knees:____
Physical Therapy: Dates:_______________________________________
Surgeries (List date and type i.e. arthroscopy, reconstruction, etc.)

Date:______________ Type:___________________________
Date:______________ Type:___________________________
Date:______________ Type:___________________________

Past Knee History - Any previous injury to injured knee or knees:

Date of injury____________________
Type of Injury____________________
Type of Treatment_________________

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CURRENT SYMPTOMS

What is the level of your pain: (Check one in each column)

Mild	Dull	No Ache
Moderate	Sharp (knife like)	Intermittent Ache
Severe	Burning	Constant Ache

Where is the pain located: (Check all that apply)

Entire front of Knee
Under kneecap
Inside of knee
Outside of knee
Deep within the knee - all over
Deep within the knee - in one area
Small local area in front of knee
Back of knee

What makes the knee pain worse: (Check all that apply)

Sitting	Stairs	Kneeling	Standing
Running	Crawling	Walking	Squatting

Do you experience any of the following with your knee: (Check all that apply)

Swelling
Giving way of the knee after pain
Giving way of the knee without warning or pain
Pain at night (awakens from sleep)
Locking - where the knee will not straighten

What are your functional limitations:

Unable to walk (crutches required)
Unable to perform household tasks
Unable to work
Unable to perform in sports
Type of sport:____

Is the pain: The same Improving Worse

Other bone or joint problems:

Pain, Where:____
Swelling, Where:____
Surgery:____

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PATIENT'S KNEE SOCIETY EVALUATION Today's Date: __/__/____

Subjects Name:____________________________ Surgeon's Name:_______________________

Affected Side: Right Left

Auto Accident Related: Yes No Work Related: Yes No

KNEE FUNCTION

Pain (Check One) .... 5Wij]hm@YjY`f7\YW_CbY

Pain	Activity
None	Bedridden (Bedridden or confined to wheelchair)
Mild or Occasional Stairs Only	Sedentary (minimal ambulation or activity)
Mild or Occasional Walking & Stairs	Semi-sedentary (white collar, bench work, light cleaning)
Moderate Occasional	Light labor (heavy cleaning, assembly line, light sports)
Moderate Continual	Moderate labor (lifts <50 lbs., moderate sports)
Severe	Heavy labor (frequently lifts 50-100 lbs, vigorous sports)

FUNCTION EVALUATION

Walking (Check One):	Stairs (Check One):	Support (Check One):
Unlimited	Normal up and down	No Support
>10 blocks	Normal up, down with rail	Cane
5-10 blocks	Up and down with rail	Two canes
< 5 blocks	Up with rail, unable down	Crutches or walker
House bound	Unable	
Unable		

Night Pain: Yes No Back Pain: Yes No Weight:_______lbs.

Current Medication (Check all that apply):

Major Analgesics	Narcotics
NSAIDS	Coumadin
Steroids (Oral)	LMWH

PLEASE COMPLETE IF YOU HAVE RECEIVED SURGERY Surgery Date: __/__/____

Overall, what is your level of satisfaction with your knee replacement surgery? (Check One)

Extremely Satisfied Very Satisfied Moderately Satisfied
Slightly Satisfied Not at all Satisfied

If you could, would you choose again to have this surgery performed on your knee: Yes No

KOOS KNEE SURVEY Today's Date: __/__/____

Name:___________________________________ Date of Birth: __/__/____

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 do your usual activities. Answer every question by selecting one from the possible answers. 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.

1. Do you have swelling in your knee:
Never Rarely Sometimes Often Always

2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?
Never Rarely Sometimes Often Always

3. Does your knee catch or hang up when moving?
Never Rarely Sometimes Often Always

4. Can you straighten your knee fully?
Never Rarely Sometimes Often Always

5. Can you bend your knee fully?
Never Rarely Sometimes Often Always

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

1. How severe is your knee joint stiffness after first waking in the morning?
Never Rarely Sometimes Often Always

2. How severe is your knee joint stiffness after sitting, lying or resting later in the day?
Never Rarely Sometimes Often Always

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

1. How often do you experience knee pain?
Never Rarely Sometimes Often Always

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

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

2. Straightening knee fully
None Mild Moderate Severe Extreme

3. Bending knee fully
None Mild Moderate Severe Extreme

4. Walking on flat surface
None Mild Moderate Severe Extreme

5. Going up or down stairs
None Mild Moderate Severe Extreme

6. At night while in bed
None Mild Moderate Severe Extreme

7. Sitting or lying
None Mild Moderate Severe Extreme

8. 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.

1. Descending stairs
None Mild Moderate Severe Extreme

2. Ascending stairs
None Mild Moderate Severe Extreme

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

1. Rising from sitting
None Mild Moderate Severe Extreme

2. Standing
None Mild Moderate Severe Extreme

3. Bending to floor/pick up an object
None Mild Moderate Severe Extreme

4. Walking on flat surface
None Mild Moderate Severe Extreme

5. Getting in/out of car
None Mild Moderate Severe Extreme

6. Going shopping
None Mild Moderate Severe Extreme

7. Putting on socks/stockings
None Mild Moderate Severe Extreme

8. Rising from bed
None Mild Moderate Severe Extreme

9. Taking off socks/stockings
None Mild Moderate Severe Extreme

10. Lying in bed (turning over, maintaining knee position)
None Mild Moderate Severe Extreme

11. Getting in/out of bath
None Mild Moderate Severe Extreme

12. Sitting
None Mild Moderate Severe Extreme

13. Getting on/off toilet
None Mild Moderate Severe Extreme

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

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

2. 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.

1. Squatting
None Mild Moderate Severe Extreme

2. Running
None Mild Moderate Severe Extreme

3. Jumping
None Mild Moderate Severe Extreme

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

5. Kneeling
None Mild Moderate Severe Extreme

QUALITY OF LIFE

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

2. Have you modified your lifestyle to avoid potentially damaging activities to your knee?
Not at all Mildly Moderately Severely Totally

3. How much are you troubled with lack of confidence in your knee?
None Mildly Moderately Severely Extremely

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

Name________________________________D.O.B__________

Please mark on the scale your level of pain for the area being surveyed only.

Please only make ONE mark.
Please DO NOT associate a number with the scale (such as from 1 – 10 scale).
Please DO NOT mark a range.

↓ EXAMPLES EXAMPLES EXAMPLES EXAMPLES EXAMPLES EXAMPLES ↓

CORRECT

I DO NOT HAVE ANY PAIN ------------------------------------|----------------------- MY PAIN COULD NOT BE WORSE

INCORRECT

6-7

I DO NOT HAVE ANY PAIN --------------------------|-------------------------------- MY PAIN COULD NOT BE WORSE

INCORRECT

⟷

I DO NOT HAVE ANY PAIN ----------------------|---------|--------------------------- MY PAIN COULD NOT BE WORSE

↑ EXAMPLES EXAMPLES EXAMPLES EXAMPLES EXAMPLES EXAMPLES ↑

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PLEASE MARK YOUR PAIN LEVEL BELOW.

I DO NOT HAVE ANY PAIN |--| MY PAIN COULD NOT BE WORSE

Instructions: Using the space bar, move the cursor along the line, then type a lower case l in the location that corresponds to your pain level.

Name__________________________________D.O.B__________

5.) During the **past 4 weeks,** have you had any of the following with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? (Mark one response on each line)

	YES	NO
a. Cut down the **amount of time** you spent on work or other activities		
a. **Accomplished less** than you would like		
a. Didn't do work or other activities as **carefully** as usual		

6.) During the **past 4 weeks,** to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (Mark one response)

Not at all | Slightly | Moderately | Quite a bit | Extremely

7.) How much bodily pain have you had during the **past 4 weeks**? (Mark one response)

None | Very Mild | Mild | Moderate | Severe | Very Severe

8.) During the **past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework)? (Mark one response)

Not at all | A little bit | Moderately | Quite a bit | Extremely

9.) These questions are about how you feel and how things have been with you during the **past 4 weeks.** For each question, please give the one answer that comes closet to the way you have been feeling. (Mark one response on each line)

How much of the time during the **past 4 weeks –**

	All Of The Time	Most Of The Time	A Good Bit Of The Time	Some Of The Time	A Little Of The Time	None Of The Time
a. Did you feel full of pep?						
b. Have you been a very nervous person?						
c. Have you felt so down in the dumps that nothing could cheer you up?						
d. Have you felt calm and peaceful						
e. Did you have a lot of energy?						
f. Have you felt downhearted and blue?						
g. Did you feel worn out?						
h. Have you been a happy person?						
i. Did you feel tired?						

10.) During the **past 4 weeks,** how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)? (Mark one response)

All of the time | Most of the time | Some of the time | A little of the time | None of the time

11.) How **TRUE** or **FALSE** is **each** of the statements for you? (Mark one response on each line)

	Definitely TRUE	Mostly TRUE	Don't Know	Mostly FALSE	Definitely FALSE
a. I seem to get sick a little easier than other people					
b. I am as healthy as anybody I know					
c. I expect my health to get worse					
d. My health is excellent					