

KOOS, JR. KNEE SURVEY

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 do 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.

Stiffness

The following question concerns 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.

1. How severe is your knee stiffness after first wakening in the morning?

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

Pain

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

2. Twisting/pivoting on your knee

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

3. Straightening knee fully

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

4. Going up or down stairs

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

5. 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.

6. Rising from sitting

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

7. Bending to floor/pick up an object

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

PLEASE CIRCLE WHICH KNEE:

+LEFT

PRINT NAME: _____

+RIGHT

DATE OF BIRTH: _____ ©2016 Hospital for Special Surgery