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_____

Page 2 Knee History

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:_____

Page 3 Knee History

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)

- ○ None
- ○ Mild or Occasional Stairs Only
- ○ Mild or Occasional Walking & Stairs
- ○ Moderate Occasional
- ○ Moderate Continual
- ○ Severe

Activity Level (Check One)

- ○ Bedridden (Bedridden or confined to wheelchair)
- ○ Sedentary (minimal ambulation or activity)
- ○ Semi-sedentary (white collar, bench work, light cleaning)
- ○ Light labor (heavy cleaning, assembly line, light sports)
- ○ Moderate labor (lifts <50 lbs., moderate sports)
- ○ Heavy labor (frequently lifts 50-100 lbs, vigorous sports)

FUNCTION EVALUATION

Walking (Check One):

- ○ Unlimited
- ○ >10 blocks
- ○ 5-10 blocks
- ○ < 5 blocks
- ○ House bound
- ○ Unable

Stairs (Check One):

- ○ Normal up and down
- ○ Normal up, down with rail
- ○ Up and down with rail
- ○ Up with rail, unable down
- ○ Unable

Support (Check One):

- ○ No Support
- ○ Cane
- ○ Two canes
- ○ Crutches or walker

Night Pain: ○ Yes ○ No Back Pain: ○ Yes ○ No Weight:_____lbs.

Current Medication (Check all that apply):

- ☐ Major Analgesics
- ☐ NSAIDS
- ☐ Steroids (Oral)
- ☐ Narcotics
- ☐ Coumadin
- ☐ 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

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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

Page 5 Knee History

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

I DO NOT HAVE ANY PAIN 6-7 ----------|---------- 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	◯	◯	◯	◯	◯