



KOOS KNEE SURVEY

eform v 3.1

Patient Name: _____

Side: Left

Patient ID: _____

Right

Date of review: (complete either the date of review or the follow up period below)

Follow up period: Pre Op OR _____ Weeks / Months / Years (add the delay and circle one)

Patients - please place an X in one box on each line to indicate your response to that question.

Symptoms

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

	Never	Rarely	Sometimes	Often	Always
Do you have swelling in your knee?	<input type="checkbox"/>				
Do you feel grinding, hear clicking or any other type of noise when your knee moves?	<input type="checkbox"/>				
Does your knee catch or hang up when moving?	<input type="checkbox"/>				

	Always	Often	Sometimes	Rarely	Never
Can you straighten your knee fully?	<input type="checkbox"/>				
Can you bend your knee fully?	<input type="checkbox"/>				

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.

	None	Mild	Moderate	Severe	Extreme
How severe is your knee joint stiffness after first wakening in the morning?	<input type="checkbox"/>				
How severe is your knee stiffness after sitting, lying or resting later in the day?	<input type="checkbox"/>				



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Pain

Never Monthly Weekly Daily Always

How often do you experience knee pain?

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

None Mild Moderate Severe Extreme

Twisting/pivoting on your knee

Straightening knee fully

Bending knee fully

Walking on flat surface

Going up or down stairs

At night while in bed

Sitting or lying

Standing upright

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.

None Mild Moderate Severe Extreme

Descending stairs

Ascending stairs



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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.

None Mild Moderate Severe Extreme

Rising from sitting

Standing

Bending to floor/pick up an object

Walking on flat surface

Getting in/out of car

Going shopping

Putting on socks/stockings

Rising from bed

Taking off socks/stockings

Lying in bed (turning over, maintaining knee position)

Getting in/out of bath or shower

Sitting

Getting on/off toilet

Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)

Light domestic duties (cooking, dusting, etc)

KOOS Knee Score 3 / 4



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.

None Mild Moderate Severe Extreme

Squatting

Running

Jumping

Twisting/pivoting on your injured knee

Kneeling

Quality of Life

Never Monthly Weekly Daily Constantly

How often are you aware of your knee problem?

Not at all Mildly Moderately Severely Totally

Have you modified your life style to avoid potentially damaging activities to your knee?

Not at all Mildly Moderately Severely Extremely

How much are you troubled with lack of confidence in your knee?

None Mild Moderate Severe Extreme

In general, how much difficulty do you have with your knee?

Thank you very much for completing all the questions in this questionnaire.