



64972

KNEE QUESTIONNAIRE

First Name

Today's Date

Surname

Date of Birth

Have you had any previous knee surgery? Yes No (If yes please tick what surgery from list below)

- Arthroscopy
- Ligament reconstruction
- Partial knee replacement
- Revision of knee surgery
- Other

Do you have other joint problems? Yes No (If yes please tick which joints below)

	No pain		Some pain			Agony	
	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
<input type="checkbox"/> Other knee	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
<input type="checkbox"/> Hips	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
<input type="checkbox"/> Shoulders	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
<input type="checkbox"/> Back	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
<input type="checkbox"/> Other <input style="width: 100px;" type="text"/>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	

Have you had any of the following?

- Heart Disease
- Diabetes
- Stroke
- Other (Please state)

How many years ago did you start having knee problems?

- >10 years
- 5-10 years
- 2-5 years
- 1-2 years
- <1 year

Have you modified your lifestyle to accommodate your knee?

- 1 - Not at all
- 2 - Mildly
- 3 - Moderately
- 4 - Severely
- 5 - Extremely

In general how much does your knee bother you?

- 1 - Not at all
- 2 - Mildly
- 3 - Moderately
- 4 - Severely
- 5 - Extremely

STIFFNESS

	1-Never	2-Rarely	3-Sometimes	4-Often	5-Always
Do you experience swelling in your knee?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often is your knee stiff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your knee catch when moving it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your knee click or grind when moving it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1-Always	2-Often	3-Sometimes	4-Rarely	5-Never
Can you fully straighten your knee?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can you bend your knee fully?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How severe is your stiffness:	1 - None	2 - Mild	3 - Moderate	4 Very bad	5 - Severe
First thing in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Later on in the day after sitting or resting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAIN

How often do you:	1 - Never	2 - Monthly	3 - Weekly	4 - Daily	5 - Always
Experience knee problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get knee pain at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you take pain medication for your knee?	1 - Never	2 - Monthly	3 - Weekly	4 - Daily	5 -> x1 daily
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much pain do you have:	1 - None	2 - Mild	3 - Moderate	4 Very bad	5-Severe
Generally in your knee?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changing direction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going up and down stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending your knee fully?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Straightening your knee fully?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MOBILITY

How far can you walk before you feel you want to stop?					
> 1 Hour 3 miles +	30-60 mins 2-3 miles	15-30 mins 1-2 miles	5-15 mins <1 mile	In the house only	Can't walk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you need an aid to help you walk?					
<input type="checkbox"/> Never	<input type="checkbox"/> On Long walks/rough ground	<input type="checkbox"/> Walking Outside	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Always	
If "yes" what aid do you use to walk?					
<input type="checkbox"/> None	<input type="checkbox"/> 1 Stick	<input type="checkbox"/> Elbow crutches	<input type="checkbox"/> Frame	<input type="checkbox"/> Wheelchair bound/Unable to walk	
Do you limp when walking?					
<input type="checkbox"/> Never (rarely)	<input type="checkbox"/> Sometimes (or just at first)	<input type="checkbox"/> Often	<input type="checkbox"/> Most of the time	<input type="checkbox"/> All of the time	
Do you feel that your knee might suddenly give way or let you down?					
<input type="checkbox"/> Never (rarely)	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Always	

Can you run? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" How far ? <input type="checkbox"/> >1 Mile <input type="checkbox"/> Half a mile <input type="checkbox"/> 100 metres <input type="checkbox"/> 50 metres <input type="checkbox"/> A few steps					
How much pain do you have during or after you have run?					
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme	



64972

GENERAL HEALTH

Would you say your health is: Excellent Very good Good Fair Poor

Compared to 1 year ago how would you rate your health in general now?

Much better Somewhat better About the same Somewhat worse Much worse

During the past 4 weeks have you had any of the following problems with work or other regular daily activities as a result of your physical health?

Cut down the amount of time you spent on work or other activities? Yes No

Accomplished less than you would have liked? Yes No

Were limited in the kind of work or activities you could do? Yes No

Took more effort to do your work or other activities? Yes No

During the past 4 weeks have you felt anxious or depressed? Yes No **If "yes" have you: :**

Cut down the amount of time you spent on work or other activities? Yes No

Accomplished less than you would have liked? Yes No

Not done your work or other activities as carefully as usual? Yes No

During the past 4 weeks to what extent has your physical health or emotional problems interfered with your normal social activities with friends and neighbours or groups?

Not at all Slightly Moderately Severely Extremely

How much bodily pain have you had during the past 4 weeks?

None A little Moderate amount Quite a bit A lot

During the past 4 weeks how much did pain interfere with your normal work (including housework and daily chores)?

Not at all Slightly Moderately Severely Extremely

During the past 4 weeks how much of the time have you have you felt :

Full of energy? All Most A good bit Some A little bit None

Nervous? All Most A good bit Some A little bit None

So down that nothing could cheer you up? All Most A good bit Some A little bit None

Relaxed and content? All Most A good bit Some A little bit None

Worn out? All Most A good bit Some A little bit None

Been happy? All Most A good bit Some A little bit None

Abnormally tired? All Most A good bit Some A little bit None



64972

GENERAL HEALTH Continued

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (eg visiting friends)?

- All Most Some A little bit None of the time

How true or false are each of the following statements for you?

"I seem to get sick a little easier than other people"

- Definitely true Mostly true Don't know Mostly false Definitely false

"I am as healthy as anybody I know"

- Definitely true Mostly true Don't know Mostly false Definitely false

"I expect my health to get worse"

- Definitely true Mostly true Don't know Mostly false Definitely false

"My health is excellent"

- Definitely true Mostly true Don't know Mostly false Definitely false



64972

SPORT, LEISURE AND LIFESTYLE

Which activities and sports matter most to you?

Please write your answers in the boxes below labelled 'ACTIVITY'.

You can write any activity of your choice. We have listed some suggestions below:

Home related activities

*Kneeling
Squatting
Sedentary pastimes
eg reading, TV
Moving Sideways*

Mild activities

*Walking
Light shopping/
housework
DIY
Twisting
Driving*

Moderate Activities

*Sexual activity
Swimming
Heavy
shopping/housework*

Active Events

*Bowls
Golf
Cycling
Field sports
Gardening
Dancing*

Impact Activities

*Running
Racket sports
Skiing
Horse riding
Cricket
Football/Rugby*

ACTIVITY

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Importance to you ?

Not Somewhat Very
 1 2 3 4 5

How often do you do this activity now?

Can't do Rarely Sometimes >2x/wk twice/week
 0 1 2 3 4 5

How much does your knee bother you during this activity now?

Does not A little A lot Bothers alot
 1 2 3 4 5

How often do you want to do this activity?

Rarely Sometimes >2x/wk twice/week
 1 2 3 4 5

ACTIVITY

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Importance to you ?

Not Somewhat Very
 1 2 3 4 5

How often do you do this activity?

Can't do Rarely Sometimes >2x/wk twice/week
 0 1 2 3 4 5

How much does your knee bother you during this activity?

Does not A little A lot Bothers alot
 1 2 3 4 5

How often do you want to do this activity?

Rarely Sometimes >2x/wk twice/week
 1 2 3 4 5

ACTIVITY

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Importance to you ?

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 1 2 3 4 5

How often do you do this activity?

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 0 1 2 3 4 5

How much does your knee bother you during this activity?

Does not A little A lot Bothers alot
 1 2 3 4 5

How often do you want to do this activity?

Rarely Sometimes >2x/wk twice/week
 1 2 3 4 5

ACTIVITY

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Importance to you ?

Not Somewhat Very
 1 2 3 4 5

How often do you do this activity?

Can't do Rarely Sometimes >2x/wk twice/week
 0 1 2 3 4 5

How much does your knee bother you during this activity?

Does not A little A lot Bothers alot
 1 2 3 4 5

How often do you want to do this activity?

Rarely Sometimes >2x/wk twice/week
 1 2 3 4 5



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OFFICE USE ONLY

First Name

Grid for entering first name

Today's Date

Grid for entering today's date

Surname

Grid for entering surname

Date of Birth

Grid for entering date of birth

RANGE OF MOVEMENT AND STABILITY - MEASURED BY GONIOMETER

1. Range of Motion (in degrees)

a. Start of knee flexion []

b. End of knee flexion []

2. Stability

Please tick the appropriate box for each measurement

A/P Instability/laxity (at full extension)

[] <5mm [] 5-9mm [] >9mm

M/L Instability/Laxity (with varus/valgus stress)

[] <5 degrees [] 6-9 degrees [] 10-14 degrees [] >14 degrees

Flexion Contracture

[] 5-9 degrees [] 10-15 degrees [] 16-20 degrees [] >20 degrees

Extension Lag

[] <10 degrees [] 10-20 degrees [] >20 degrees

Alignment (varus/valgus)

[] 0-4 degrees [] 5-10 degrees [] 11-15 degrees [] Other

TIMED GET UP AND GO [] (mins:secs)



64972

ADDITIONAL POST OPERATIVE ONLY INFORMATION

Today's Date

/ /

Date of knee surgery

/ /

Surgeon

PATIENT LABEL

Surgery performed
 Total Knee Replacement Medial UKA Lateral UKA PFJ arthroplasty Revision of joint surgery

Does your knee replacement keep you from doing anything that you would like to do?
 Yes No

Are you as active now as you expected to be?
 Yes No

Are you more or less active now than before your knee surgery?
 More Less About the Same

Does your knee feel normal to you?
 Yes No

How satisfied are you with your knee surgery?
 1 Very dissatisfied 2 Dissatisfied Somewhat satisfied Satisfied Very satisfied