

PRE OPERATIVE KNEE QUESTIONNAIRE – MATER ORTHOPAEDIC OUTCOME REGISTRY

Name: _____

Date of Birth: _____

Today's Date: _____

Operation Date: _____

Treating Surgeon: _____



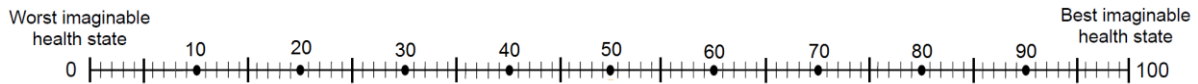
LEFT KNEE RIGHT KNEE BOTH KNEES Current Height (cm) _____ Weight (kg) _____

Current Medication _____

EQ-5D. By placing a tick, please indicate which statements best describe your own health state today

Problems with Mobility – walking about	<input type="checkbox"/> no	<input type="checkbox"/> some	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> I am unable
Problems with Self -Care - washing or dressing	<input type="checkbox"/> no	<input type="checkbox"/> some	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> I am unable
Problems with Usual Activities (e.g. work, study, housework, family or leisure activities)	<input type="checkbox"/> no	<input type="checkbox"/> some	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> I am unable
Pain/Discomfort	<input type="checkbox"/> none	<input type="checkbox"/> slight	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> extreme
Anxiety/Depression	<input type="checkbox"/> none	<input type="checkbox"/> slight	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> extreme

On the scale below, please indicate how good or bad your own health is today, in your opinion



KOOS JR KNEE SCORE Please TICK the most appropriate response to your condition **during the LAST WEEK...**

How severe is your knee joint **stiffness** after first waking in the morning? none mild moderate severe extreme

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

Twisting/Pivoting on your knee	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> extreme
Straightening knee fully	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> extreme
Going up or down stairs	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> extreme
Standing upright	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> extreme

Function. For each of the following please indicate the **degree of difficulty** you have had in the last week due to your knee

Rising from sitting	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> extreme
Bending to floor/picking up object	<input type="checkbox"/> none	<input type="checkbox"/> mild	<input type="checkbox"/> moderate	<input type="checkbox"/> severe	<input type="checkbox"/> extreme

On a scale of 0-10, please indicate your average pain over the last 7 days in the **knee** which will be operated on?

0 1 2 3 4 5 6 7 8 9 10
No pain at all Worst pain imaginable

On a scale of 0-10, please indicate your average pain in your **lower back** over the last 7 days?

0 1 2 3 4 5 6 7 8 9 10
No pain at all Worst pain imaginable

On a scale of 0 to 10, please indicate your average pain in your **feet** over the last 7 days?

0 1 2 3 4 5 6 7 8 9 10
No pain at all Worst pain imaginable

On a scale of 0 to 10, please indicate what you expect your average **knee** pain to be in **6 months' time**

0 1 2 3 4 5 6 7 8 9 10
No pain at all Worst pain imaginable

On a scale of 0 to 100, please indicate what you expect your **general health** to be in **6 months' time**

10 20 30 40 50 60 70 80 90 100
Worst health you can imagine Best health you can imagine

Please tick one box which best describes your expected **mobility** in **6 months' time**.

No problems slight problems moderate problems severe problems unable to walk

NAME:

Date:

LEFT KNEE

RIGHT KNEE

PITTSBURGH SLEEP QUALITY INDEX

During the past month.....

How many hours of actual sleep do you get at night? (This may be different than the number of hrs you spend in bed)

>7 hours

6-7 hours

5-6 hours

<5 hours

During the past month, how would you rate your sleep quality overall?

Very Good

Fairly Good

Fairly Bad

Very Bad

OXFORD KNEE SCORE

During the past four weeks.....

1) How would you describe the pain you usually have from your knee?

None

Very mild

Mild

Moderate

Severe

2) Have you had any trouble with washing and drying yourself (all over) because of your knee?

No trouble at all

Very little trouble

Moderate trouble

Extreme difficulty

Impossible to do

3) Have you had any trouble getting in and out of a car or using public transport because of your knee? (With or without a stick)

No trouble at all

Very little trouble

Moderate trouble

Extreme difficulty

Impossible to do

4) For how long are you able to walk before the pain in your knee becomes severe? (With or without a stick)

No pain/>30 min

16 to 30 min

5 to 15 min

Around the house

Not at all – severe on walking

5) After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your knee

Not at all painful

Slightly painful

Moderately painful

Very painful

Unbearable

6) Have you been limping when walking, because of your knee?

Rarely/never

Sometimes or just at first

Often, not just at first

Most of the time

All of the time

7) Could you kneel down and get up again afterwards

Yes, easily

With little difficulty

With moderate difficulty

With extreme difficulty

No, impossible

8) Are you troubled by pain in your knee at night in bed?

No nights

Only 1 or 2 nights

Some nights

Most nights

Every night

9) How much has pain from your knee interfered with your usual work? (including housework)

Not at all

A little bit

Moderately

Greatly

Totally

10) Have you felt that your knee might suddenly "give away" or let you down?

Rarely/never

Sometimes

Often

Most of time

All of time

11) Could you do household shopping on your own?

Yes, easily

With little difficulty

With moderate difficulty

With extreme difficulty

No, impossible

12) Could you walk down a flight of stairs?

Yes, easily

With little difficulty

With moderate difficulty

With extreme difficulty

No, impossible

13. Do you have any problems with your other knee?

Yes

No

14. Do you have any problems walking for other reasons (eg pain from other joints, back pain, chest pain, or other medical conditions)?

Yes

No