KOOS Knee Survey: Knee Injury and Osteoarthritis Outcome Score

Name _____ Date_____

*Please circle the response that best describes your symptoms/stiffness/pain performing specific activities during the **last week**.*

Symptoms:

S1. Do you have swelling in your knee?

Never Rarely Sometimes Often Always

S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?

Never Rarely Sometimes Often Always

S3. Does your knee catch or hang up when moving?

Never Rarely Sometimes Often Always

S4. Can you straighten your knee fully?

Never Rarely Sometimes Often Always

S5. Can you bend your knee fully?

Never Rarely Sometimes Often Always

Stiffness:

S6. How severe is you knee joint stiffness after first waking up in the morning?

None Mild Moderate Severe Extreme

S7. How severe is your knee stiffness after sitting, lying or resting later in the day?

None Mild Moderate Severe Extreme

Pain: *Circle the answer that describes your amount of pain while performing the following activities.*

P1. How often do you experience knee pain?

Never Monthly Weekly Daily Always

P2. Twisting Pivoting on your knee

None Mild Moderate Severe Extreme

P3. Straightening knee fully

None Mild Moderate Severe Extreme

P4. Bending knee fully

None Mild Moderate Severe Extreme

P5. Walking on a flat surface

None Mild Moderate Severe Extreme

P6. Going up or down stairs

None Mild Moderate Severe Extreme

P7. At night while in bed

None Mild Moderate Severe Extreme

P8. Sitting or lying

None Mild Moderate Severe Extreme

P9. Standing upright

None Mild Moderate Severe Extreme

Function, Daily Living:

A1. Descending stairs

None Mild Moderate Severe Extreme

A2. Ascending stairs

None Mild Moderate Severe Extreme

A3. Rising from sitting

None Mild Moderate Severe Extreme

A4. Standing

None Mild Moderate Severe Extreme

A5. Bending to floor/picking up an object

None Mild Moderate Severe Extreme

A6. Walking on a flat surface

None Mild Moderate Severe Extreme

A7. Getting in/out of a car

None Mild Moderate Severe Extreme

A8. Going shopping

None Mild Moderate Severe Extreme

A9. Putting on socks/stockings

None Mild Moderate Severe Extreme

A10. Rising from bed

None Mild Moderate Severe Extreme

A11. Taking off socks/stockings

None Mild Moderate Severe Extreme

A12. Lying in bed (turning over, maintaining knee position)

None Mild Moderate Severe Extreme

A13. Getting in/out of the bath

None Mild Moderate Severe Extreme

A14. Sitting

None Mild Moderate Severe Extreme

A15. Getting on/off the toilet

None Mild Moderate Severe Extreme

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc.)

None Mild Moderate Severe Extreme

A17. Light domestic duties (cooking, dusting, etc.)

None Mild Moderate Severe Extreme

Function, sport and recreational activities: ***Circle the answer that describes your amount of difficulty.***

SP1. Squatting

None Mild Moderate Severe Extreme

SP2. Running

None Mild Moderate Severe Extreme

SP3. Jumping

None Mild Moderate Severe Extreme

SP4. Twisting/pivoting on you injured knee

None Mild Moderate Severe Extreme

SP5. Kneeling

None Mild Moderate Severe Extreme

Quality of life:

Q1. How often are you aware of your knee problem?

Never Monthly Weekly Daily Always

Q2. Have you modified your lifestyle to avoid activities that may potentially damaging your knee?

Not at all Mildly Moderately Severely Totally

Q3. How much are you troubled with lack of confidence in your knee?

None Mild Moderate Severe Extreme

Q4. In general, how much difficulty do you have with your knee?

None Mild Moderate Severe Extreme