

# **KOOS Knee Survey** Knee Injury and Osteoarthritis Outcome Score

Name \_\_\_\_\_ Date \_\_\_\_\_

Instructions: Please circle the response that best describes your symptoms/stiffness/pain performing specific activities during the past week. Please answer all questions

	<b>Never</b>	<b>Monthly</b>	<b>Weekly</b>	<b>Daily</b>	<b>Always</b>
1) <u>How Often is your knee painful?</u>	0	1	2	3	4

## **What degree of pain have you experienced in the past week when...?**

	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extreme</b>
2) <u>Twisting/Pivoting on your knee</u>	0	1	2	3	4
3) <u>Straighten knee fully</u>	0	1	2	3	4
4) <u>Bending knee fully</u>	0	1	2	3	4
5) <u>Walking on flat surfaces</u>	0	1	2	3	4
6) <u>Going up or down stairs</u>	0	1	2	3	4
7) <u>At night while in bed</u>	0	1	2	3	4
8) <u>Sitting or lying</u>	0	1	2	3	4
9) <u>Standing upright</u>	0	1	2	3	4

	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extreme</b>
10) <u>How severe is your knee stiffness after first awakening in the morning?</u>	0	1	2	3	4
11) <u>How severe is your knee stiffness after sitting, lying, or resting later in the day?</u>	0	1	2	3	4

	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>	<b>Always</b>
12) <u>Do you have swelling in your knee?</u>	0	1	2	3	4
13) <u>Do you feel grinding, hear clicking or any other type of noise when your knee moves?</u>	0	1	2	3	4
14) <u>Does your knee catch or hang up when moving?</u>	0	1	2	3	4

	<b>Always</b>	<b>Often</b>	<b>Sometimes</b>	<b>Rarely</b>	<b>Never</b>
15) <u>Can you straighten your knee fully?</u>	0	1	2	3	4
16) <u>Can you bend your knee fully?</u>	0	1	2	3	4

## **What difficulty have you experienced in the past week when...?**

	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extreme</b>
17) <u>Descending stairs</u>	0	1	2	3	4
18) <u>Ascending stairs</u>	0	1	2	3	4
19) <u>Rising from sitting</u>	0	1	2	3	4
20) <u>Standing</u>	0	1	2	3	4

21) <u>Bending to floor/picking up an object</u>	0	1	2	3	4
22) <u>Walking on flat surface</u>	0	1	2	3	4
23) <u>Getting in/out of a car</u>	0	1	2	3	4
24) <u>Going shopping</u>	0	1	2	3	4
25) <u>Putting on socks/stockings</u>	0	1	2	3	4
26) <u>Rising from bed</u>	0	1	2	3	4
27) <u>Taking off socks/stockings</u>	0	1	2	3	4
28) <u>Lying in bed (turning over, maintaining knee position)</u>	0	1	2	3	4
29) <u>Getting in/out of bath or shower</u>	0	1	2	3	4
30) <u>Sitting</u>	0	1	2	3	4
31) <u>Getting on/off toilet</u>	0	1	2	3	4
32) <u>Heavy domestic duties (Shoveling, scrubbing floors, etc.)</u>	0	1	2	3	4
33) <u>Light domestic duties (cooking, dusting, etc.)</u>	0	1	2	3	4
34) <u>Squatting</u>	0	1	2	3	4
35) <u>Running</u>	0	1	2	3	4
36) <u>Jumping</u>	0	1	2	3	4
37) <u>Turning/twisting on your injured knee</u>	0	1	2	3	4
38) <u>Kneeling</u>	0	1	2	3	4

### **Knee Related Quality of Life**

	<b>Never</b>	<b>Monthly</b>	<b>Weekly</b>	<b>Daily</b>	<b>Always</b>
39) <u>How often are you aware of your knee problems?</u>	0	1	2	3	4
	<b>Not at all</b>	<b>Mildly</b>	<b>Moderately</b>	<b>Severely</b>	<b>Totally</b>
40) <u>Have you modified your lifestyle to avoid potentially damaging activities to your knee?</u>	0	1	2	3	4
41) <u>How troubled are you with lack of confidence in your knee?</u>	0	1	2	3	4
	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>	<b>Extreme</b>
42) <u>In general, how much difficulty do you have with your knees?</u>	0	1	2	3	4