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## KOOS Knee Survey

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Age: \_\_\_\_\_

This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to perform your usual activities. Answer **every** question by ticking the appropriate box, only **one** box for each question. If you are unsure about how to answer a question, please give the best answer you can.

### Symptoms

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

**Do you have swelling in your knee?**

Never  Rarely  Sometimes  Often  Always

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

Never  Rarely  Sometimes  Often  Always

**Does your knee catch or hang up when moving?**

Never  Rarely  Sometimes  Often  Always

**Can you straighten your knee fully?**

Never  Rarely  Sometimes  Often  Always

**Can you bend your knee fully?**

Never  Rarely  Sometimes  Often  Always

### 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.

**How severe is your knee joint stiffness after first waking up in the morning?**

None  Mild  Moderate  Severe  Extreme

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

None  Mild  Moderate  Severe  Extreme

### Pain

**How often do you experience knee pain?**

Never  Monthly  Weekly  Daily  Always

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

**1) Twisting/pivoting on your knee?**

None  Mild  Moderate  Severe  Extreme

**2) Straightening the knee fully?**

None  Mild  Moderate  Severe  Extreme

**3) Bending the knee fully?**

None  Mild  Moderate  Severe  Extreme

**4) Walking on a flat surface?**

None  Mild  Moderate  Severe  Extreme

**5) Going up or down stairs?**

None                       Mild                       Moderate                       Severe                       Extreme

**6) At night in bed?**

None                       Mild                       Moderate                       Severe                       Extreme

**7) Sitting or lying?**

None                       Mild                       Moderate                       Severe                       Extreme

**8) Standing upright?**

None                       Mild                       Moderate                       Severe                       Extreme

**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:

**1) Descending stairs?**

None                       Mild                       Moderate                       Severe                       Extreme

**2) Ascending stairs?**

None                       Mild                       Moderate                       Severe                       Extreme

**3) Rising from sitting?**

None                       Mild                       Moderate                       Severe                       Extreme

**4) Standing**

None                       Mild                       Moderate                       Severe                       Extreme

**5) Bending to floor/pick up an object?**

None                       Mild                       Moderate                       Severe                       Extreme

**6) Walking on a flat surface?**

None                       Mild                       Moderate                       Severe                       Extreme

**7) Getting in/out of a car?**

None                       Mild                       Moderate                       Severe                       Extreme

**8) Going shopping?**

None                       Mild                       Moderate                       Severe                       Extreme

**9) Putting on socks/tights?**

None                       Mild                       Moderate                       Severe                       Extreme

**10) Rising from bed?**

None                       Mild                       Moderate                       Severe                       Extreme

**11) Taking off socks/tights?**

None                       Mild                       Moderate                       Severe                       Extreme

**12) Lying in bed? (turning over, maintaining position)**

None                       Mild                       Moderate                       Severe                       Extreme

**13) Getting in/out of bath?**

None                       Mild                       Moderate                       Severe                       Extreme

**14) Sitting?**

None                       Mild                       Moderate                       Severe                       Extreme

**15) Getting on/off the toilet?**

None                       Mild                       Moderate                       Severe                       Extreme

**16) Heavy domestic duties? (moving heavy boxes, scrubbing floors etc.)**

None                       Mild                       Moderate                       Severe                       Extreme

**17) Light domestic duties? (cooking, dusting etc.)**

None                       Mild                       Moderate                       Severe                       Extreme

**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:

**1) Squatting?**

None                       Mild                       Moderate                       Severe                       Extreme

**2) Running?**

None                       Mild                       Moderate                       Severe                       Extreme

**3) Jumping?**

None                       Mild                       Moderate                       Severe                       Extreme

**4) Twisting/pivoting on your injured knee?**

None                       Mild                       Moderate                       Severe                       Extreme

**5) Kneeling?**

- None                       Mild                       Moderate                       Severe                       Extreme

**Quality of life**

**How often are you aware of your knee problem?**

- Never                       Monthly                       Weekly                       Daily                       Constantly

**Have you modified your lifestyle to avoid potentially damaging activities to your knee?**

- Not at all                       Mildly                       Moderately                       Severely                       Totally

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

- Not at all                       Mildly                       Moderately                       Severely                       Extremely

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

- None                       Mild                       Moderate                       Severe                       Extreme

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