LEXINGTON MEDICAL CENTER

KOOS, JR. KNEE SURVEY

Knee Injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS, JR.), English version 1.0

INSTRUCTIONS: 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 do 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.

Stiffness

The following question concerns 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.

1. How severe is your knee stiffness after first wakening in the morning?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

Pain

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

2. Twisting/pivoting on your knee

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

3. Straightening knee fully

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

4. Going up or down stairs

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

5. 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.

6. Rising from sitting

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

7. Bending to floor/pick up an object

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

FORMS ARE FOR POST-SURGICAL TOTAL KNEE REPLACEMENT ORTHOPAEDIC OFFICE VISITS.

PATIENT'S NAME:_____

M#:_____

OR STICKER

TODAY'S DATE:_____

DATE OF SURGERY:_____

FOLLOW UP VISIT:_____

6032-011-1 (7/19)