



Brian J. Cole, MD MBA

SURVEY INFORMATION

Patient: _____ Date: _____

The attached survey includes questionnaire forms regarding general information and history about your current joint problem. In addition, there are specific questions about your general health, functioning at work and sports, activities of daily living, symptoms and pain.

Questions are designed to assist in current evaluation and measure post-operative outcomes through a detailed clinical scoring system. Please answer each question on every page, with your best single answer, except in the few cases where multiple answers are indicated.

Some questions are intentionally similar on different forms so that the required answers can be used in a variety of assessments on how well your surgery or treatment has done and how satisfied you are with the outcome. Please answer all questions even if they reappear on different forms.

Thank you for your time and attention in answering all questions to complete this survey. It not only provides a basis for your future care, rehabilitation and treatment, but also becomes part of a statistical database which enables research studies for the future advancement of cartilage repair procedures.

Although the information may be shared in future research studies, it will be protected and kept confidential. Prior to extracting, exporting or merging any statistical data, it will be de-identified to comply with HIPAA regulations. Your participation is appreciated and don't hesitate to ask if you should have any questions.



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KG1 Patient Demographics, History and Exam –Page 1 of 2

Patient Name: _____ **Date of Birth:** _____ Male Female

Address: _____ **Zip** _____ **City** _____ **State** _____

Phone: _____ **Email Address:** _____

Which joint you are seeing the Dr about? Knee Shoulder Other **Affected Side:** Right Left

Surgeon: _____ **Referring Doctor:** _____

Hospital/Clinic: _____ **Insurance Co:** _____

What is your current weight: _____ **Pounds**

What is your height: _____ **Feet/Inches**

Date injury occurred or was first noticed: _____ **Date of Examination:** _____

Is this a Worker’s Compensation case: Yes No

Is your opposite joint: Normal Nearly normal Abnormal Severely abnormal

Any other joint problems? (check those affected)

- Hips Ankles Shoulders Elbows
- Hands Feet Spine Neck Knees

Was the onset of your symptoms?

Sudden Gradual

What was the cause of your current joint problem?

Sport Car accident Motor bike Work accident Other accident No known injury

How long have you had your symptoms?

Less than one month Between 1 and 3 months Between 4 and 12 months More than one year

If more than one year, how many years? _____



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KG1 Patient Demographics, History and Exam –Page 2 of 2

WORK AND FUNCTION

What type of work did you do before injury or joint problem?

- Office
- Light manual
- Student
- Domestic duties
- Heavy manual
- Unemployed due to joint problem
- Non manual work but involves walking
- Retired
- Unemployed – other reason

What was your work status before injury or joint problem?

- Full time
- Part time
- Don't do paid work
- Unable to do usual work

What is your current functional status?

- I can do everything
- I am restricted; many things are not possible
- I can do nearly everything
- I am severely restricted in everything I do

Is the type of work you do the same as before your injury or joint problem?

- Yes
- No

If your work status is different now is this due to your injury or joint problem

- Yes
- No

SPORTS

What was your sporting activity level before your current joint problem?

- Sports professional
- Well trained, frequent sports
- High level competitive sports
- Sports sometimes
- No sport

Is the level of sporting activity you can do now, the same, higher or lower as before your injury or joint problem?

- Same
- Higher
- Lower

If your sporting level is different now, is this due to your injury or joint problem?

- Yes
- No

Please list your main sports: _____

Comments:

S1 SF36 - General Health Survey - Page 1 of 3

Patient Name: _____ Date of Birth: _____

Evaluation Date: _____ Joint: Knee Shoulder Other Side: Right Left

1. In general, would you say your health is?

- 1 Excellent
- 2 Very Good
- 3 Good
- 4 Fair
- 5 Poor

2. Compared to one year ago, how would you rate your health in general now?

- 1 Much better now than 1 year ago
- 2 Somewhat better now than 1 year ago
- 3 About the same as 1 year ago
- 4 Somewhat worse now than 1 year ago
- 5 Much worse now than 1 year ago

3. How much does your health now limit you in the following activities that you might do during a typical day?

	Limited a lot	Limited a little	Not limited
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
c. Lifting or carrying groceries	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
d. Climbing several flights of stairs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
e. Climbing one flight of stairs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
f. Bending, kneeling or stooping	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
g. Walking more than a mile	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
h. Walking several hundred yards	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
i. Walking one hundred yards	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
j. Bathing or dressing yourself	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Cut down on the amount of time you spent on work or other activities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Accomplished less than you would like	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Were limited in the kind of work or other activities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. Had difficulty performing the work or other activities (for example, it took extra effort)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Cut down on the amount of time you spent on work or other activities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Accomplished less than you would like	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Did work or other activities less carefully than usual	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?

- 1 Not At All
- 2 Slightly
- 3 Moderately
- 4 Quite a Bit
- 5 Extremely

7. How much bodily pain have you had during the past 4 weeks?

- 1 None
- 2 Very Mild
- 3 Mild
- 4 Moderate
- 5 Severe
- 6 Very Severe

S1 SF36 - General Health Survey - Page 3 of 3

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- 1 Not at All
 2 A Little Bit
 3 Moderately
 4 Quite a Bit
 5 Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of life?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Have you been very nervous?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Have you felt so down in the dumps that nothing could cheer you up?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. Have you felt calm and peaceful?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e. Did you have a lot of energy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f. Have you felt downhearted and depressed?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
g. Did you feel worn out?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
h. Have you been happy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
i. Did you feel tired?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- 1 All of the time
 2 Most of the time
 3 Some of the time
 4 A little of the time
 5 None of the time

11. How TRUE or FALSE is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. I am as healthy as anybody I know	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. I expect my health to get worse	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. My health is excellent	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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Patient Name: _____ Date of Birth: _____

Evaluation Date: _____ Joint: Knee Shoulder Other Side: Right Left

1) In general, would you say your health is?

1 Excellent 2 Very Good 3 Good 4 Fair 5 Poor

How much does your health now limit you in the following activities you might do during a typical day?

	Limited a lot	Limited a little	Not limited at all
2) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3) Climbing several flights of stairs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
4) Accomplished less than you would like	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
5) Were limited in the kind of work or other activities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

S2 SF12 – General Health Survey- Page 2 of 2

During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems, such as feeling depressed or anxious?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
6) Accomplished less than you would like	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
7) Did work or other activities less carefully than usual	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

8) During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

1 Not at All 2 A Little Bit 3 Moderately 4 Quite a Bit 5 Extremely

These questions are about how you feel and how things have been, much of the time, with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9) Have you felt calm and peaceful?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
10) Did you have a lot of energy?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
11) Have you felt downhearted and depressed?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

12) During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities, like visiting with friends, relatives, etc.?

1 All of the time 2 Most of the time 3 Some of the time 4 A little of the time 5 None of the time



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S14_1 Knee Society Score - Patient

Patient Name: _____ Date Of Birth: _____

Date of Evaluation: _____ Date of Surgery/Initial Exam: _____

Which Joint: Knee Shoulder Other Which Side: Right Left

1. How much pain do you have when you are walking?

1 None 2 Mild or Occasional 3 Moderate

2. How much pain does your knee cause when going up and down stairs?

1 None 2 Mild or Occasional 3 Moderate 4 Severe

3. How much pain does your knee cause when you are at rest?

1 None 2 Mild or Occasional 3 Moderate 4 Severe

4. How does your knee affect your walking ability? 5. How do you go up stairs?

- 1 I can walk unlimited distances. 1 I go up stairs normally one foot in front of the other.
2 I can walk 10-20 blocks. 2 I use the hand rail for balance.
3 I can walk 5-10 blocks. 3 I use the hand rail to pull myself up.
4 I can walk 1-5 blocks. 4 I cannot climb stairs.
5 I can walk less than one block.
6 I cannot walk at all.

6. How do you go down stairs?

- 1 I go down stairs normally one foot in front of the other. 1 I get out of a chair normally without support.
2 I use the hand rail for balance. 2 I use the arm rests for balance.
3 I use the hand rail to support myself. 3 I use the arm rests to push myself.
4 I cannot come down stairs. 4 I cannot get out of a chair.

8. What type of support do you use when walking?

1 None 2 Cane 3 2 Canes
4 Crutches 5 Walker



S15 Koos Knee Score - Page 1 of 4

Patient Name: _____ Date of Birth: _____

Date of Evaluation: _____

Date of Surgery/Initial Exam: _____

Which Joint: Knee Shoulder Other

Which Side: Right Left

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.

Symptoms

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

S1. Do you have swelling in your knee?

1 Never 2 Rarely 3 Sometimes 4 Often 5 Always

S1. Do you feel grinding; hear clicking or any other type of noise when your knee moves?

1 Never 2 Rarely 3 Sometimes 4 Often 5 Always

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

1 Never 2 Rarely 3 Sometimes 4 Often 5 Always

S4. Can you straighten your knee fully?

1 Always 2 Often 3 Sometimes 4 Rarely 5 Never

S5. Can you bend your knee fully?

1 Always 2 Often 3 Sometimes 4 Rarely 5 Never

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.

S6. How severe is your knee joint stiffness after first wakening in the morning?

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

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

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme



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S15 Koos Knee Score - Page 2 of 4

Pain

P1. How often do you experience knee pain?

1 Never 2 Monthly 3 Weekly 4 Daily 5 Always

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

P2. Twisting/pivoting on your knee

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

P3. Straightening knee fully

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

P4. Bending knee fully

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

P5. Walking on flat surface

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

P6. Going up or down stairs

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

P7. At night while in bed

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

P8. Sitting or lying

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

P9. Standing upright

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

S15 Koos Knee Score - Page 3 of 4

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.

A1. Descending stairs	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A2. Ascending stairs	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A3. Rising from sitting	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A4. Standing	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A5. Bending to floor/pick up an object	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A6. Walking on flat surface	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A7. Getting in/out of car	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A8. Going shopping	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A9. Putting on socks/stockings	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A10. Rising from bed	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A11. Taking off socks/stockings	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A12. Lying in bed (turning over, maintaining knee position)	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A13. Getting in/out of bath	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A14. Sitting	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A15. Getting on/off toilet	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme
A17. Light domestic duties (cooking, dusting, etc)	1 <input type="checkbox"/> None	2 <input type="checkbox"/> Mild	3 <input type="checkbox"/> Moderate	4 <input type="checkbox"/> Severe	5 <input type="checkbox"/> Extreme

S15 Koos Knee Score - Page 4 of 4

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.

SP1. Squatting

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

SP2. Running

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

SP3. Jumping

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

SP4. Twisting/pivoting on your injured knee

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

SP5. Kneeling

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

Quality of Life

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

1 Never 2 Monthly 3 Weekly 4 Daily 5 Constantly

Q2. Have you modified your life style to avoid potentially damaging activities to your knee?

1 Not at all 2 Mildly 3 Moderately 4 Severely 5 Totally

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

1 Not at all 2 Mildly 3 Moderately 4 Severely 5 Extremely

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

1 None 2 Mild 3 Moderate 4 Severe 5 Extreme

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



Brian J. Cole, MD MBA

S17 LYSHOLM

Patient Name: _____ Date of Birth: _____

Date of Evaluation: _____

Date of Surgery/Initial Exam: _____

Which Joint: Knee Shoulder Other

Which Side: Right Left

1. Do you have a limp?

- 1 No
- 2 Slight limp or limp periodically
- 3 Severe limp and constantly

2. What support do you need for walking?

- 1 None
- 2 Stick or crutch
- 3 I am unable to weight bear.

3. Does your knee lock?

- 1 No locking or catching sensations
- 2 Catching sensation but no locking
- 3 Locking - occasionally
- 4 Locking - frequently
- 5 Locked joint on examination (it is locked now)

4. How unstable is your Knee?

- 1 It never gives way
- 2 Rarely during athletics or other severe exertion
- 3 Frequently during athletics
- 4 Occasionally during daily activities
- 5 Often during daily activities
- 6 Every step

5. How painful is your Knee?

- 1 No pain
- 2 Inconstant and slight during severe exertion
- 3 Marked during severe exertion
- 4 Marked on or after walking 2km
- 5 Marked on or after walking less than 2km
- 6 Constant

6. Do you have swelling in your knee?

- 1 None
- 2 On severe exertion
- 3 On ordinary exertion
- 4 Constant

7. Can you climb stairs?

- 1 No problems
- 2 Slightly impaired
- 3 One step at a time
- 4 Impossible

8. Can you squat?

- 1 No problems
- 2 Slightly impaired
- 3 Not beyond 90 degrees
- 4 Impossible

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Patient Name: _____ Date Of Birth: _____

Date of Evaluation: _____ Date of Surgery/Initial Exam: _____

Which Joint: Knee Shoulder Other

Which Side: Right Left



SYMPTOMS*:

*Grade symptoms at the highest activity level at which you think you could function without significant problems, even if you are not actually performing activities at this level.



1. What is the highest level of activity that you can perform without significant knee pain?

- 1 Very strenuous activities like jumping or pivoting as in basketball or soccer
 2 Strenuous activities like heavy physical work, skiing or tennis
 3 Moderate activities like moderate physical work, running or jogging
 4 Light activities like walking, housework or yard work
 5 Unable to perform any of the above activities due to knee pain

2. During the past 4 weeks, or since your injury, how often have you had pain?

Never	0	1	2	3	4	5	6	7	8	9	10	Constant
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. If you have pain, how severe is it?

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

4. During the past 4 weeks, or since your injury, how stiff or swollen was your knee?

1 Not at all 2 Mildly 3 Moderately 4 Very 5 Extremely

5. What is the highest level of activity you can perform without significant swelling in your knee?

- 1 Very strenuous activities like jumping or pivoting as in basketball or soccer
 2 Strenuous activities like heavy physical work, skiing or tennis
 3 Moderate activities like moderate physical work, running or jogging
 4 Light activities like walking, housework, or yard work
 5 Unable to perform any of the above activities due to knee swelling

6. During the past 4 weeks, or since your injury, did your knee lock or catch?

1 Yes 2 No

7. What is the highest level of activity you can perform without significant giving way in your knee?

- 1 Very strenuous activities like jumping or pivoting as in basketball or soccer
 2 Strenuous activities like heavy physical work, skiing or tennis
 3 Moderate activities like moderate physical work, running or jogging
 4 Light activities like walking, housework or yard work
 5 Unable to perform any of the above activities due to giving way of the knee

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SPORTS ACTIVITIES:

8. What is the highest level of activity you can participate in on a regular basis?
- 1 Very strenuous activities like jumping or pivoting as in basketball or soccer
 - 2 Strenuous activities like heavy physical work, skiing or tennis
 - 3 Moderate activities like moderate physical work, running or jogging
 - 4 Light activities like walking, housework or yard work
 - 5 Unable to perform any of the above activities due to knee


9. How does your knee affect your ability to?


	Not difficult at all	Minimally difficult	Moderately Difficult	Extremely difficult	Unable to do
a. Go up stairs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Go down stairs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Kneel on the front of your knee	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. Squat	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e. Sit with your knee bent	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f. Rise from a chair	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
g. Run straight ahead	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
h. Jump and land on your involved leg	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
i. Stop and start quickly	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

FUNCTION:


10. How would you rate the function of your knee on a scale of 0 to 10 with 10 being normal, excellent function and 0 being the inability to perform any of your usual daily activities which may include sports?


FUNCTION PRIOR TO YOUR KNEE INJURY:

Cannot perform daily activities 0 1 2 3 4 5 6 7 8 9 10 No limitation 



CURRENT FUNCTION OF YOUR KNEE:

Cannot perform daily activities 0 1 2 3 4 5 6 7 8 9 10 No limitation 





Brian J. Cole, MD MBA

S20 Tegner Activity

Patient Name: _____ Date of Birth: _____

Date of Evaluation: _____ Date of Surgery/Initial Exam: _____

Which Joint: Knee Shoulder Other Which Side: Right Left

Please indicate in the spaces below the HIGHEST level of activity that you participated in BEFORE YOUR INJURY and the highest level you are able to participate in CURRENTLY.

BEFORE INJURY OR NORMAL STATUS: Level _____ CURRENT: Level _____

Level 10	Competitive sports- soccer, football, rugby (national elite)
Level 9	Competitive sports- soccer, football, rugby (lower divisions), ice hockey, wrestling, gymnastics, basketball
Level 8	Competitive sports- racquetball or bandy, squash or badminton, track and field athletics (jumping, etc.), down-hill skiing
Level 7	Competitive sports- tennis, running, motorcars speedway, handball Recreational sports- soccer, football, rugby, bandy, ice hockey, basketball, squash, racquetball, running
Level 6	Recreational sports- tennis and badminton, handball, racquetball, down-hill skiing, jogging at least 5 times per week
Level 5	Work- heavy labour (construction, etc.) Competitive sports- cycling, cross-country skiing Recreational sports- jogging on uneven ground at least twice weekly
Level 4	Work- moderately heavy labour (e.g. truck driving, etc.)
Level 3	Work- light labour (nursing, etc.)
Level 2	Work- light labour Walking on uneven ground possible, but impossible to back pack or hike
Level 1	Work- sedentary (secretarial, etc.)
Level 0	Sick leave or disability pension because of knee problems

S21 Brittberg Peterson -Page 1 of 3

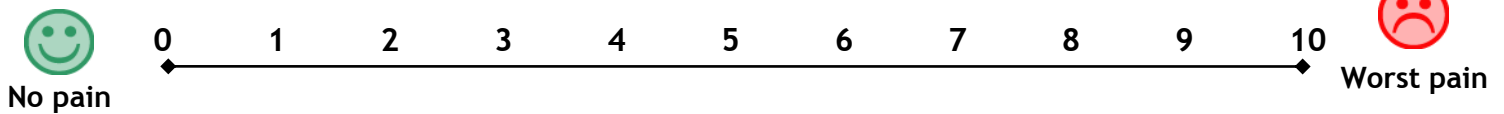
Patient Name: _____ Date of Birth: _____

Date of Evaluation: _____ Date of Surgery/Initial Exam: _____

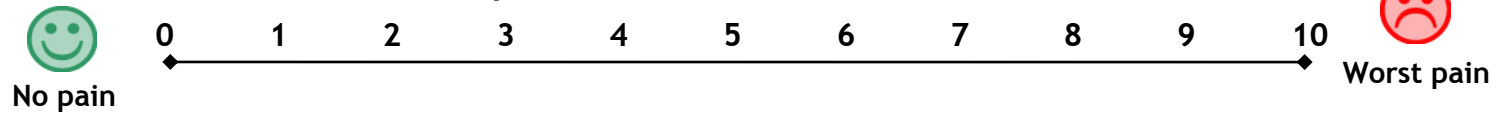
Which Joint: Knee Shoulder Other Which Side: Right Left

Please circle the number on the scale at the level which most corresponds to how you feel for each question since your last visit. 0 is the best and 10 is the worst

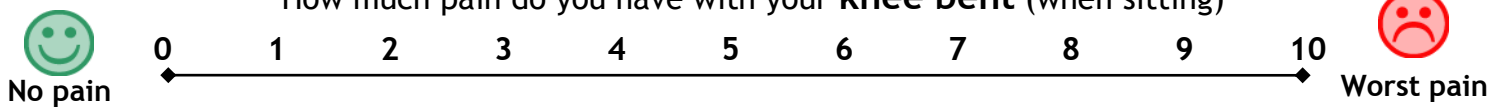
How much **pain** have you felt in your affected joint when it is resting?



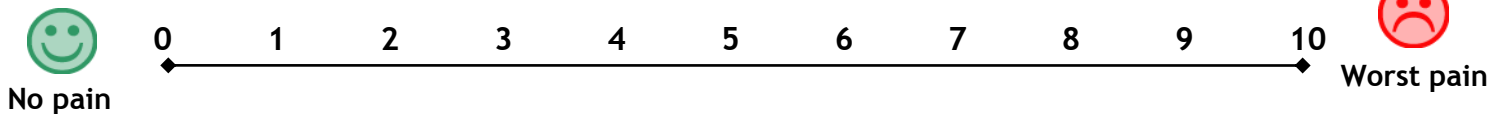
How much **pain** do you feel when your **joint is moving**?



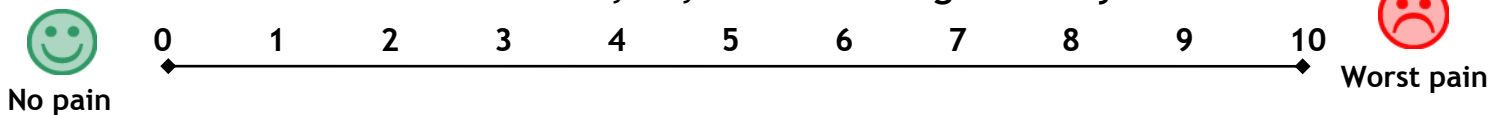
How much pain do you have with your **knee bent** (when sitting)



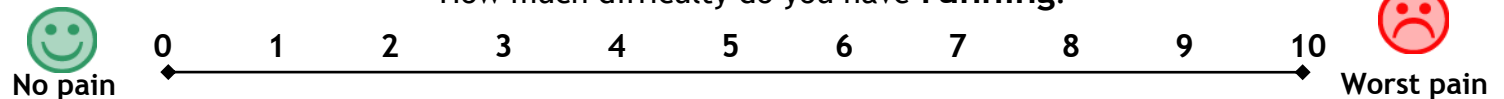
Do you **limp**?



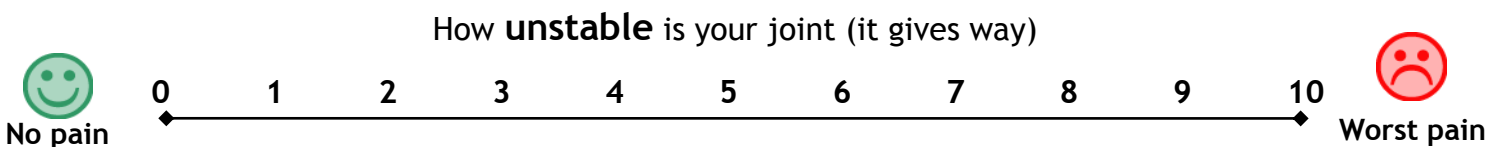
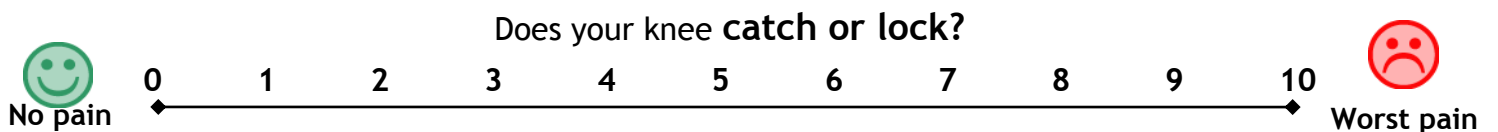
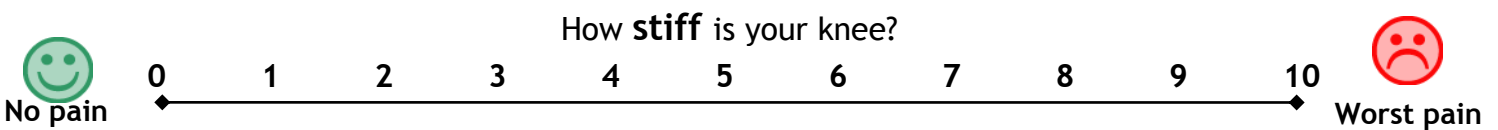
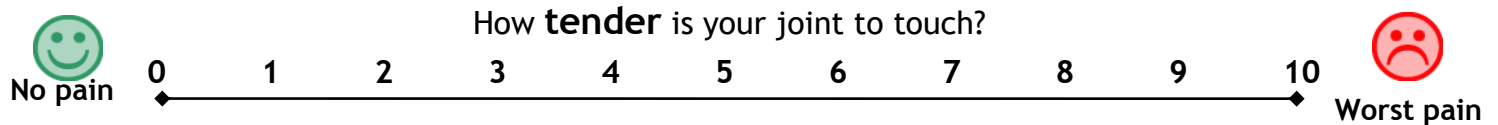
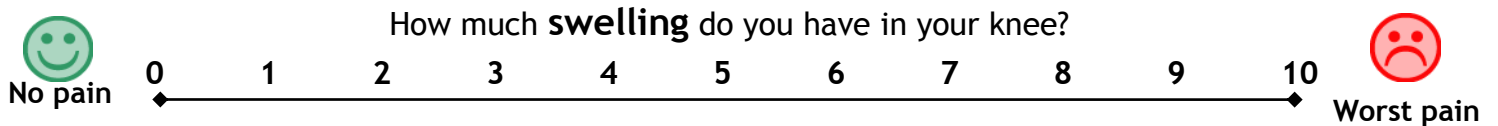
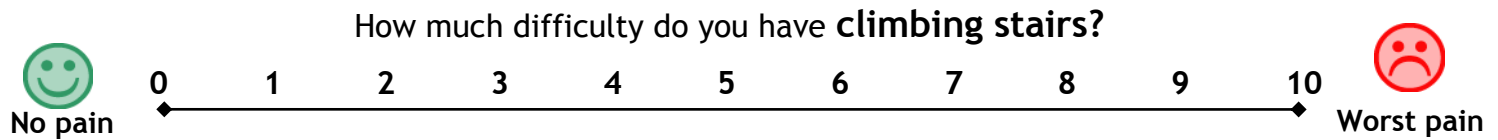
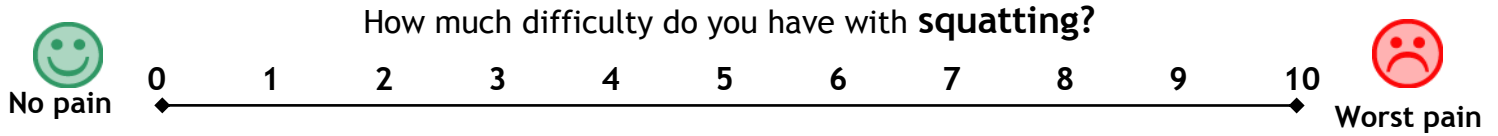
How much difficulty do you have **walking normally**?



How much difficulty do you have **running**?



Brittberg - Peterson - Page 2 of 3



Brittberg - Peterson - Page 3 of 3

After surgery only

Did you achieve your goal with surgery?

- 1 Yes
- 2 No - because of pain, swelling or giving way
- 3 No - but I have changed my goal, I no longer have the desire to participate in activities

How is your knee after surgery?

- 1 My knee has improved
- 2 My knee has stayed the same
- 3 My knee has become worse but is still tolerable
- 4 My knee has become significantly worse and is not tolerable

How would you rate the effect the surgical procedure had on your knee?

- 1 My knee has improved because of the surgery
- 2 I am uncertain about the effect of the surgery
- 3 The surgery was not useful



Brian J. Cole, MD MB

S23 Marx Activity

Patient Name: _____ Date of Birth: _____

Date of Evaluation: _____ Date of Surgery/Initial Exam: _____

Which Joint: Knee Shoulder Other

Which Side: Right Left

Before Injury or normal status	Less than one time in a month	One time in a month	One time in a week	2 or 3 times in a week	4 or more times in a week
Running: running while playing a sport or jogging					
Cutting: changing directions while running					
Decelerating: coming to a quick stop while running					
Pivoting: turning your body with your foot planted while playing a sport; For example: skiing, skating, kicking, throwing, hitting a ball (golf, tennis, squash), etc.					

Currently	Less than one time in a month	One time in a month	One time in a week	2 or 3 times in a week	4 or more times in a week
Running: running while playing a sport or jogging					
Cutting: changing directions while running					
Decelerating: coming to a quick stop while running					
Pivoting: turning your body with your foot planted while playing a sport; For example: skiing, skating, kicking, throwing, hitting a ball (golf, tennis, squash), etc.					



Brian J. Cole, MD MBA

KG17 Psychovitality Score

Patient Name: _____ Date of Birth: _____

Surgeon : _____ Date of evaluation: ____/____/____

Side: Right Left

How important is it for you to be involved in competitive sports?

Not important Slightly important Very Important

How fast do you expect to return to your sport after surgery?

1 year 6 months 3 months

How much time are you willing to spend for rehabilitation after surgery?

1 x week 3 x week everyday

Do you have any doubts in your ability to return to your previous sports?

Yes No

Would you be content if after surgery you can only manage to go back to an activity level for the same sports that is less than your pre injury sporting level?

Yes No

After you surgery would you be willing to settle for a less strenuous sporting activity than you were previously engaged in?

Yes No

KG19 Pain Expectations

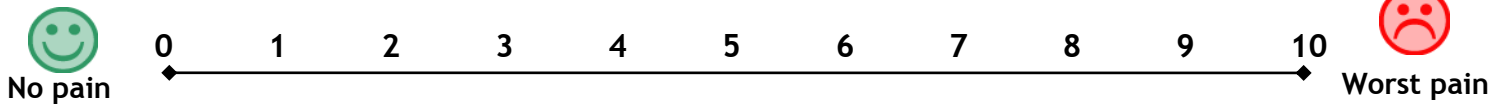
Patient Name _____ Date of Birth _____

Date _____

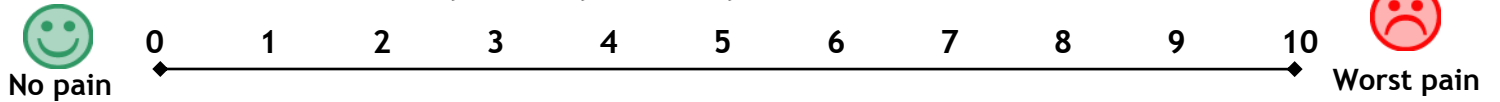
Side Right Left

Please circle the number on the scale at the level which most corresponds to how you feel for each question since your last visit. 0 is the best and 10 is the worst

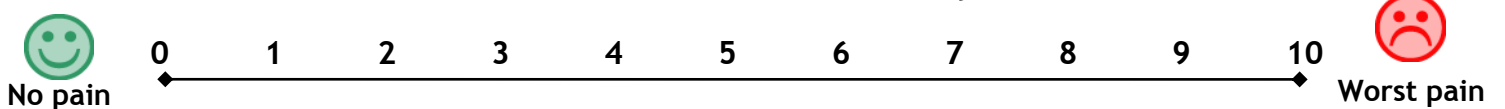
How much **pain** have you felt in your affected joint the majority of the time?



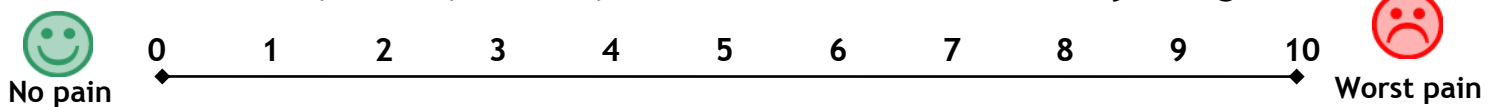
How do you rate your ability to do **strenuous work**?



How do you rate your ability to do **sedentary activities**?



How do you rate your ability to do **normal activities of daily living**?



How well did this operation **meet your expectations**?
(After surgery only)

