

<h2 style="margin: 0;">The Arthroplasty Foundation</h2> <p style="margin: 0;">Donald L. Pomeroy, M.D.</p> <h3 style="margin: 0;">KOOS EVALUATION</h3>		Date of Evaluation <div style="border: 1px solid black; height: 20px; width: 100%; margin-bottom: 5px;"></div> DD-MMM-YYYY		
Site No.	Subject No.	Subject Name/Initials <small>Last Name, first name or FML initial</small>	Date of Birth	Side <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both

**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 as indicated by marking **(X)** the appropriate box. Mark **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?

- |        |                                |                                 |                                    |                                |                                 |
|--------|--------------------------------|---------------------------------|------------------------------------|--------------------------------|---------------------------------|
| Right: | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Often | <input type="checkbox"/> Always |
| Left:  | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Often | <input type="checkbox"/> Always |

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

- |        |                                |                                 |                                    |                                |                                 |
|--------|--------------------------------|---------------------------------|------------------------------------|--------------------------------|---------------------------------|
| Right: | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Often | <input type="checkbox"/> Always |
| Left:  | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Often | <input type="checkbox"/> Always |

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

- |        |                                |                                 |                                    |                                |                                 |
|--------|--------------------------------|---------------------------------|------------------------------------|--------------------------------|---------------------------------|
| Right: | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Often | <input type="checkbox"/> Always |
| Left:  | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Often | <input type="checkbox"/> Always |

S4. Can you straighten your knee fully?

- |        |                                 |                                |                                    |                                 |                                |
|--------|---------------------------------|--------------------------------|------------------------------------|---------------------------------|--------------------------------|
| Right: | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Left:  | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |

S5. Can you bend your knee fully?

- |        |                                 |                                |                                    |                                 |                                |
|--------|---------------------------------|--------------------------------|------------------------------------|---------------------------------|--------------------------------|
| Right: | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Left:  | <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> 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?

- |        |                               |                               |                                   |                                 |                                  |
|--------|-------------------------------|-------------------------------|-----------------------------------|---------------------------------|----------------------------------|
| Right: | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> Extreme |
| Left:  | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> Extreme |

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

- |        |                               |                               |                                   |                                 |                                  |
|--------|-------------------------------|-------------------------------|-----------------------------------|---------------------------------|----------------------------------|
| Right: | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> Extreme |
| Left:  | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> Extreme |

**PAIN:**

P1. How often do you experience pain?

- |        |                                |                                  |                                 |                                |                                 |
|--------|--------------------------------|----------------------------------|---------------------------------|--------------------------------|---------------------------------|
| Right: | <input type="checkbox"/> Never | <input type="checkbox"/> Monthly | <input type="checkbox"/> Weekly | <input type="checkbox"/> Daily | <input type="checkbox"/> Always |
| Left:  | <input type="checkbox"/> Never | <input type="checkbox"/> Monthly | <input type="checkbox"/> Weekly | <input type="checkbox"/> Daily | <input type="checkbox"/> Always |

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

P2. Twisting/pivoting on your knee?

- |        |                               |                               |                                   |                                 |                                  |
|--------|-------------------------------|-------------------------------|-----------------------------------|---------------------------------|----------------------------------|
| Right: | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> Extreme |
| Left:  | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> Extreme |

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Last Name, first name or FML initial				

**PAIN, CONTINUED:**

P3. Straightening knee fully?					
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P4. Bending knee fully?					
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P5. Walking on flat surface?					
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P6. Going up or down stairs?					
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P7. At night while in bed?					
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P8. Sitting or lying?					
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P9. Standing upright?					
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> 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.

A1. Descending stairs?					
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A2. Ascending stairs?					
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A3. Rising from sitting?					
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A4. Standing?					
Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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				<input type="checkbox"/> Right
		Last Name, first name or FML initial		<input type="checkbox"/> Left
				<input type="checkbox"/> Both

**FUNCTION, CONTINUED:**

A5. Bending to floor/pick up an object?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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A6. Walking on flat surface?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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A7. Getting in/out of car?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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A8. Going shopping?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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A9. Putting on socks/stockings?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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A10. Rising from bed?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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A11. Taking off socks/stockings?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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A13. Getting in/out of bath?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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A14. Sitting?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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A15. Getting on/off of toilet?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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Last Name, first name or FML initial				

**FUNCTION, CONTINUED:**

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

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> 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.

SP1. Squatting?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

SP2. Running?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

SP3. Jumping?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

SP4. Twisting/pivoting on your injured knee?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

SP5. Kneeling?

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

**QUALITY OF LIFE:**

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

Right:	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Constantly
Left:	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Constantly

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

Right:	<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely	<input type="checkbox"/> Totally
Left:	<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely	<input type="checkbox"/> Totally

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

Right:	<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely	<input type="checkbox"/> Extremely
Left:	<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely	<input type="checkbox"/> Extremely

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

Right:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Left:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme