**OrthoMichigan**

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| **KOOS, JR. KNEE SURVEY** |
| **Pre Operative**   **Post Operative**  3-4 months  9-13 months  **Estimated Surgery Date**:   |  |  | | --- | --- | | Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Account Number: \_\_\_\_\_\_\_\_\_\_\_ | | Surgeon: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Side: 🗌Right 🗌Left | | | |

**INSTRUCTIONS:** This survey asks for your view about your knee. This information will help us keep track of how well you are able to perform different 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 so that you answer all the questions.

**Stiffness**

The following questions concern the amount of joint stiffness you have experienced during the

**last** **week** in your knees. 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?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Twisting/pivoting on your knee | | | | |
| None | Mild | Moderate | Severe | Extreme |
| 1. Straightening knee fully | | | | |
| None | Mild | Moderate | Severe | Extreme |
| 1. Going up or down stairs | | | | |
| None | Mild | Moderate | Severe | Extreme |
| 1. 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. Rising from sitting | | | | |
| None | Mild | Moderate | Severe | Extreme |
| 1. Bending to floor/pickup an object | | | | |
| None | Mild | Moderate | Severe | Extreme |
| **MARCQI Patient Reported Outcomes Opioid Questions**  **Instructions:**  Answer each question by marking the most appropriate box, giving only one answer per question.  If you are unsure how to answer a question, pleas give the best answer you can.   1. Do you take opioid pain medications every day or most days (e.g. Hydrocodone, Norco,   Vicodin, Oxycodone, Morphine, Codeine, etc.)?   |  |  | | --- | --- | | YES  (If YES, please continue to #2 below) | NO  ( If NO, please skip to the next page) |  1. Why do you take this opioid pain medication(s)?   Operative Joint Pain  Other pain in different area of your body  Operative Joint Pain AND other pain in different are of your body  Other reason, not for pain | | | | |
|  |  |  |  |  |

**Global Health Scale**

|  |  |
| --- | --- |
| **Today’s Date:** Report Date | |
| **Patient Name:** Patient Name | **Account No.:** Code |

**Please respond to each item by marking one box in each row**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | **Excellent** | | | **Very**  **good** | | | **Good** | | | | **Fair** | | **Poor** | | |
| Global01 | In general, would you say your health is: ..… | | | 5 | | | 4 | | | 3 | | | | 2 | | 1 | | |
| Global02 | In general, would you say your quality of life is: ….. | | | 5 | | | 4 | | | 3 | | | | 2 | | 1 | | |
| Global03 | In general, how would you rate your physical health? ….. | | | 5 | | | 4 | | | 3 | | | | 2 | | 1 | | |
| Global04 | In general, how would you rate your mental health, including your mood and your ability to think?..... | | | 5 | | | 4 | | | 3 | | | | 2 | | 1 | | |
| Global05 | In general, how would you rate your satisfaction with your social activities and relationships? ….. | | | 5 | | | 4 | | | 3 | | | | 2 | | 1 | | |
| Global09 | In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.) ….. | | | 5 | | | 4 | | | 3 | | | | 2 | | 1 | | |
|  |  | | | **Completely** | | | **Mostly** | | | **Moderately** | | | | **A Little** | | **Not at all** | | |
| Global06 | To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries or moving a chair? ….. | | | 5 | | | 4 | | | 3 | | | | 2 | | 1 | | |
|  | **Continue on next page …** | | | | | | | | | | | | | | | | | |
| In the past 7 days … | | | | | | | | | | | | | | | | | | |
|  |  | | **Never** | | | | **Rarely** | | | **Sometimes** | | | | **Often** | | **Always** | | |
| Global10 | How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable? ….. | | 1 | | | | 2 | | | 3 | | | | 4 | | 5 | | |
|  |  | | **None** | | | | **Mild** | | | **Moderate** | | | | **Severe** | | **Very Severe** | | |
| Global08 | How would you rate your fatigue on average? ….. | | 1 | | | | 2 | | | 3 | | | | 4 | | 5 | | |
| Global07 | How would you rate your pain on average? ….. | 0 | 1 | | 2 | 3 | | 4 | 5 | | 6 | 7 | 8 | | 9 | | 10 |
|  |  | **No**  **Pain** |  | |  |  | |  |  | |  |  |  | |  | | **Worst imaginable pain** |

**Additional Patient Reported Outcomes Questions**

**Instructions:**

Answer each question by marking the most appropriate box, giving only one answer per question.

If you are unsure how to answer a question, please give the best answer you can.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. What amount of pain have you experienced in the last week in your other Knee? … | | | | | |
| None | Mild | Moderate | Severe | Extreme |  |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. My BACK PAIN at the moment is? … | | | | | |
| None | Very Mild | Moderate | Fairly Severe | Very Severe | Worst Imaginable |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. How comfortable are you filling out medical forms by yourself? … | | | | | |
| Extremely | Quite a bit | Somewhat | A little bit | Not at all |  |
|  |  |  |  |  |  |