1-YEAR POST OPERATION

Complete these surveys and return them to the Joint & Spine Center 1 year after your surgery date. Theres is a designated area on the form for you to include your name, date of birth, your surgeon's name, date of surgery, and which knee underwent a joint replacement.

Greater Baltimore Medical Center
Joint and Spine Center, office 5835
6701 North Charles Street
Towson, MD 21204

Complete this questionnaire **only if you do not have an e-mail address**.
Please mail it back to:
GBMC's Joint & Spine Center

KOOS, JR. KNEE SURVEY

1 Year Post-Op

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
☐	☐	☐	☐	☐

Patient Name:_____Date of Birth: ___/___/____Surgeon's Name_____

Date of Surgery: ___/___/____ Right, Left, or Bilateral Knee?_____ Today's Date ___/___/____