Knee Survey

NYU Hospital for Joint Diseases
NYU LANGONE MEDICAL CENTER

Eric J. Strauss, MD
Assistant Professor of Orthopaedic Surgery
Division of Sports Medicine

Last Name _____ First Name _____ Date ____ / ____ / ____

CURRENT PROBLEM

Is your problem in the: ☐ Right knee ☐ Left knee ☐ Both knees

What is the problem with your knee?

_____

_____

When did the problem start? ____ / ____ / ____ Did it start: ☐ Gradually ☐ Suddenly

Is your problem getting: ☐ Worse ☐ Better ☐ Staying the same

Was this a result of an injury? ☐ Yes ☐ No

If yes, please describe how it happened: _____

Rate the overall condition of your knee at the present time. Check only one box below.

☐ 0 **cannot perform daily activities** ☐ 1 ☐ 2 **poor** ☐ 3 ☐ 4 **fair** ☐ 5 ☐ 6 **good** ☐ 7 ☐ 8 ☐ 9 ☐ 10 **normal**

poor- Have significant limitations that affect activities of daily living.
fair- Have moderate limitations that affect activities of daily living, no sports possible.
good- Have some limitations with sports but I can participate; I compensate.
normal/excellent- Able to do whatever I wish (any sport) with no problems.

Rate the function of your knee prior to your injury.

☐ 0 **cannot perform daily activities** ☐ 1 ☐ 2 **poor** ☐ 3 ☐ 4 **fair** ☐ 5 ☐ 6 **good** ☐ 7 ☐ 8 ☐ 9 ☐ 10 **normal**

PAIN QUESTIONS

Are you having pain in your knee? ☐ Yes ☐ No

Location of pain: ☐ Inner side ☐ Back of knee ☐ Front/kneecap ☐ All over ☐ Outer side

How often do you experience pain? ☐ Never ☐ Monthly ☐ Weekly ☐ Daily ☐ Always

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

How **severe** is your pain?

No pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Worst pain imaginable

Describe your pain (check one):

☐ Constant
☐ Comes and goes

Describe your pain (check all that apply):

☐ Dull ☐ Sharp ☐ Burning
☐ Throbbing ☐ Aching

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Which of the following best describes your level of knee pain?

- ☐ I have no pain in my knee
- ☐ I have occasional which is slight and present only after severe exertion
- ☐ I have marked pain during severe exertion
- ☐ I have marked pain after walking more than 1 mile
- ☐ I have marked pain after walking less than 1 mile
- ☐ I have constant pain

What amount of knee <u>pain</u> have you experienced the last week during the following activities?

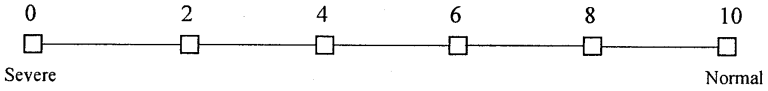
	None	Mild	Moderate	Severe	Extreme
Twisting/pivoting your knee	☐	☐	☐	☐	☐
Straightening knee fully	☐	☐	☐	☐	☐
Bending knee fully	☐	☐	☐	☐	☐
Walking on flat surface	☐	☐	☐	☐	☐
Going up or down stairs	☐	☐	☐	☐	☐
At night while in bed	☐	☐	☐	☐	☐
Sitting or lying	☐	☐	☐	☐	☐
Standing upright	☐	☐	☐	☐	☐

Using the KEY below, check the boxes on the four scales to describe the highest level you are able to reach <u>without</u> having symptoms.

KEY
10= **Normal** knee, able to do strenuous work/sports with jumping, hard pivoting
8= **Able to do moderate** work/sports with running, turning and twisting; have symptoms with strenuous work/sports
6= **Able to do light** work/sports with no running, twisting or jumping; have symptoms with moderate work/sports
4= **Able to do activities of daily living** alone; have symptoms with light work/sports
2= **Moderate symptoms** (frequent, limiting) with activities of daily living
0= **Severe symptoms** (constant, not relieved) with activities of daily living

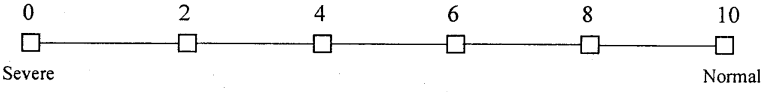
Pain

Swelling



Partial Giving-Way (partial knee collapse, do not fall to the ground)

Full Giving-Way (knee collapse occurs with actual falling to the



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KNEE SYMPTOMS

Do you experience buckling or giving-way of your knee?

- ☐ No, never
- ☐ Yes, rarely during sporting activities or other severe exertion
- ☐ Yes, frequently during sporting activities or other severe exertion
- ☐ Yes, occasionally during daily activities
- ☐ Yes, frequently during daily activities
- ☐ Yes, on every step

Do you have swelling in your knee?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

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

- ☐ Not at all
- ☐ Mildly
- ☐ Moderately
- ☐ Very
- ☐ Extremely

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

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

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

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

What is the highest level of activity you can perform **without** significant knee **pain**?

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

How severe is your knee **stiffness** after waking in the **morning**?

- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Extreme

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

- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Extreme

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

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Does your knee **catch or lock** when moving?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

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ACTIVITIES OF DAILY LIVING

For each of the following activities, please indicate the degree of difficulty you have experienced in the last week due to your knee.

	None	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Extreme Difficulty
Standing	☐	☐	☐	☐	☐
Walking on flat surface	☐	☐	☐	☐	☐
Going up stairs	☐	☐	☐	☐	☐
Going down stairs	☐	☐	☐	☐	☐
Getting in/out of car	☐	☐	☐	☐	☐
Going shopping	☐	☐	☐	☐	☐
Sitting with knee bent	☐	☐	☐	☐	☐
Rising from sitting	☐	☐	☐	☐	☐
Lying in bed (turning over)	☐	☐	☐	☐	☐
Rising from bed	☐	☐	☐	☐	☐
Putting on socks/stockings	☐	☐	☐	☐	☐
Taking off socks/stockings	☐	☐	☐	☐	☐
Getting in/out of bath	☐	☐	☐	☐	☐
Getting on/off toilet	☐	☐	☐	☐	☐
Heavy housework (scrubbing floors, moving heavy boxes)	☐	☐	☐	☐	☐
Light housework (cooking, dusting)	☐	☐	☐	☐	☐
Kneeling on the front of your knee	☐	☐	☐	☐	☐
Bending to floor/pick up an object	☐	☐	☐	☐	☐
Full squat	☐	☐	☐	☐	☐

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What statement best describes the way that you walk?

- ☐ I never walk with a limp
- ☐ I rarely walk with a limp or I walk with a slight limp
- ☐ I walk with a constant and severe limp

Do you presently use a support while you walk?

- ☐ I can walk without crutches or a cane
- ☐ I can put some weight on my leg, but I need at least one crutch or a cane to walk
- ☐ I cannot put any weight on my leg while walking

Can you **straighten** your knee fully?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Can you **bend** your knee fully?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

SPORTS FUNCTION

Which best describes your level of sports activity?

Currently	Before your knee injury
☐ 4 to 7 times per week	☐ 4 to 7 times per week
☐ 1 to 3 times per week	☐ 1 to 3 times per week
☐ 1 to 3 times per month	☐ 1 to 3 times per month
☐ No sports	☐ No sports

Which best describes the *type of activity* you participate in?

Currently (choose one)		Before your knee injury (choose one)
☐ Jumping, pivoting, cutting	(basketball, football, soccer, volleyball, gymnastics)	☐ Jumping, pivoting, cutting
☐ Running, twisting, turning	(running, tennis, hockey, skiing, wrestling)	☐ Running, twisting, turning
☐ No running, twisting or jumping	(cycling, swimming)	☐ No running, twisting or jumping
☐ Activities of daily living without problems		☐ Activities of daily living without problems
☐ Moderate problems with daily activities		☐ Moderate problems with daily activities
☐ Severe problems with daily activities		☐ Severe problems with daily activities

How much difficulty do you have currently with your injured knee while:

Running	Jumping	Stopping and Starting Quickly
☐ None	☐ None	☐ None
☐ Mild	☐ Mild	☐ Mild
☐ Moderate	☐ Moderate	☐ Moderate
☐ Severe	☐ Severe	☐ Severe
☐ Unable/Haven't tried	☐ Unable/Haven't tried	☐ Unable/Haven't tried

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QUALITY OF LIFE

Does your knee allow you to sleep comfortably? ☐ Yes ☐ No

How often are you aware of your knee problem?

☐ Never ☐ Monthly ☐ Weekly ☐ Daily ☐ Constantly

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

☐ Not at all ☐ Mildly ☐ Moderately ☐ Severely ☐ Totally

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

☐ Not at all ☐ Mildly ☐ Moderately ☐ Severely ☐ Totally

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

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

What have you used for your symptoms?			**Did you get relief?**		
	Yes	No	Yes	No	
Medication	☐	☐	☐	☐	Type: _____
Physical Therapy	☐	☐	☐	☐	How long did you attend? _____
Injections	☐	☐	☐	☐	Describe: _____
Surgery	☐	☐	☐	☐	Describe: _____
Other	☐	☐	☐	☐	Describe: _____

Does your kneecap (patella) feel like it's sliding out? ☐ Yes ☐ No

Has your kneecap ever dislocated? ☐ Yes ☐ No

If yes, how many times? _____

Datesof dislocations: _____

Treatment: _____

What tests have you already had concerning your knee problem?

☐ x-rays result: _____
☐ CT scan result: _____
☐ MRI result: _____
☐ EMG result: _____
☐ arthrogram result: _____
☐ other result: _____

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CURRENT HEALTH ASSESSMENT

In general, would you say your health is:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
Climbing several flights of stairs	☐	☐	☐

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

	Yes	No
Accomplished less than you would like	☐	☐
Were limited in the kind of work or other activities	☐	☐

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

	Yes	No
Accomplished less than you would like	☐	☐
Didn't do work or other activities as carefully as usual	☐	☐

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

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

These questions are about how you feel and how things have been with you during the last 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 last 4 weeks:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

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

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Thank you for completing this information!