

SUBJECTIVE KNEE EVALUATION FORM

Name:

First
Last

Date:

Physician:

Date of Injury:

SYMPTOMS*:

*Grade symptoms at the highest activity level at which you think you could function without significant symptoms, 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?

- Very strenuous activities 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 pain

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

- 0 1 2 3 4 5 6 7 8 9 10
Never Constant

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

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

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

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

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

- Very strenuous activities 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

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

- Yes No

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

- Very strenuous activities 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 giving way of the knee

SPORTS ACTIVITIES:

8. What is the highest level of activity you can participate in on a regular basis?

- Very strenuous activities 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

		Not difficu	Minimal ly	Moderate ly	Extreme ly	Unab le to
a.	Go up stairs					
b.	Go down stairs					
c.	Kneel on the front of your knee					
d.	Squat					
e.	Sit with your knee bent					
f.	Rise from a chair					
g.	Run straight ahead					
h.	Jump and land on your involved leg					
i.	Stop and start quickly					

Unable to perform any of the above activities due to knee 9. How does your knee affect your ability to:

- | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
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| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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:

- | | | | | |
|-----------------------------------|-----------------------|-----------------------|---|---|
| Couldn't perform daily activities | <input type="radio"/> | <input type="radio"/> | 0 | 1 |
| | | | 2 | 3 |
| | | | 4 | 5 |
| | | | 6 | 7 |

8
10

9

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

No limitation in daily activities

CURRENT FUNCTION OF YOUR KNEE:

0 1 2 3 4 5 6 7 8 9 10

Cannot perform daily activities ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ No limitation in daily activities

IKDC Score

Instructions

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your lower limb problem** for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

Activity	Extreme difficult y or unable to perform	Quite a bit of difficult	Modera te	A little bit of difficult	No difficul
1. Any of your usual work, housework or school activities.	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3. Getting into or out of the bath.	0	1	2	3	4
4. Walking between rooms.	0	1	2	3	4
5. Putting on your shoes or socks.	0	1	2	3	4
6. Squatting.	0	1	2	3	4
7. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8. Performing light activities around your home.	0	1	2	3	4
9. Performing heavy activities around your home.	0	1	2	3	4
10. Getting into or out of a car.	0	1	2	3	4
11. Walking 2 blocks.	0	1	2	3	4
12. Walking a mile.	0	1	2	3	4
13. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14. Standing for 1 hour.	0	1	2	3	4
15. Sitting for 1 hour.	0	1	2	3	4

16. Running on even ground.	0	1	2	3	4
17. Running on uneven ground.	0	1	2	3	4
18. Making sharp turns while running fast.	0	1	2	3	4
19. Hopping.	0	1	2	3	4
20. Rolling over in bed.	0	1	2	3	4
Column Totals:	0	1	2	3	4

SF-12 Health Survey

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. **Answer each question by choosing just one answer.** If you are unsure how to answer a question, please give the best answer you can.

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

₁ Excellent ₂ Very good ₃ Good ₄ Fair ₅ Poor

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

	YES, limit ed a	YES, limit ed a	NO, not limite
2. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Climbing several flights of stairs.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

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
4. Accomplished less than you would like.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
5. Were limited in the kind of work or other activities.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

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 any emotional problems (such as feeling depressed or anxious)?

	YES	NO
6. Accomplished less than you would like.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
7. Did work or activities less carefully than usual .	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

8. During the past 4 weeks, how much did pain interfere with your normal work (including 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 have been feeling during the past 4 weeks.

All of the Mos t of the A good bit S o m e o f A littl e of Non e of the

9. Have you felt calm & peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you felt down-hearted and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

blue?

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...

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 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

Patient name:	Date:	PCS:	MCS:
Visit type (circle one)			
Preop	3 week	3 month	6 month
		12	24 month
			Other:

All of the
Most of the
A good
Some of
A little of
None of the

9. Have you felt calm & peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you felt down-hearted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

blue?

All of the
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None of the

9. Have you felt calm & peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you felt down-hearted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

blue?