

KOOS-12

Instructions: This questionnaire asks for your views about your knee. Answer every question by marking 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.

Pain

1. How often do you experience knee pain?

<input checked="" type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
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What amount of knee pain have you experienced the last week during the following activities?

2. Walking on a flat surface

<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
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3. Going up or down stairs

<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
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4. Sitting or lying

<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
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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.

5. Rising from sitting

<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
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6. Standing

<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
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7. Getting in/out of car

<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
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8. Twisting/pivoting on your injured knee

<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
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Quality of Life

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

<input checked="" type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Constantly
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10. Have you modified your life style to avoid activities potentially damaging to your knee?

<input checked="" type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely	<input type="checkbox"/> Totally
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11. How much are you troubled with lack of confidence in your knee?

<input checked="" type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely	<input type="checkbox"/> Extremely
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12. In general, how much difficulty do you have with your knee?

<input checked="" type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
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