

DATE:

PATIENT DETAILS:

(apply sticky label)

PROBLEMS BECAUSE OF YOUR KNEE

During the past 4 weeks.....

✓ tick one box for every question

During the past 4 weeks.....				
How would you describe the pain you <u>usually</u> have from your knee?				
None <input type="checkbox"/>	Very mild <input type="checkbox"/>	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>
During the past 4 weeks.....				
Have you had any trouble with washing and drying yourself (all over) <u>because of your knee</u> ?				
No trouble at all <input type="checkbox"/>	Very little trouble <input type="checkbox"/>	Moderate trouble <input type="checkbox"/>	Extreme difficulty <input type="checkbox"/>	Impossible to do <input type="checkbox"/>
During the past 4 weeks.....				
Have you had any trouble getting in and out of a car or using public transport <u>because of your knee</u> ? (which ever you would tend to use)				
No trouble at all <input type="checkbox"/>	Very little trouble <input type="checkbox"/>	Moderate trouble <input type="checkbox"/>	Extreme difficulty <input type="checkbox"/>	Impossible to do <input type="checkbox"/>
During the past 4 weeks.....				
For how long have you been able to walk before <u>pain from your knee</u> becomes severe? (with or without a stick)				
No pain/ More than 30 minutes <input type="checkbox"/>	16 to 30 minutes <input type="checkbox"/>	5 to 15 minutes <input type="checkbox"/>	Around the house only <input type="checkbox"/>	Not at all -pain severe when walking <input type="checkbox"/>
During the past 4 weeks.....				
After a meal (sat at a table), how painful has it been for you to stand up from a chair <u>because of your knee</u> ?				
Not at all painful <input type="checkbox"/>	Slightly painful <input type="checkbox"/>	Moderately painful <input type="checkbox"/>	Very painful <input type="checkbox"/>	Unbearable <input type="checkbox"/>
During the past 4 weeks.....				
Have you been limping when walking <u>because of your knee</u> ?				
Rarely/ never <input type="checkbox"/>	Sometimes, or just at first <input type="checkbox"/>	Often, not just at first <input type="checkbox"/>	Most of the time <input type="checkbox"/>	All of the time <input type="checkbox"/>

P.T.O.

During the past 4 weeks.....

✓ tick one box for every question

During the past 4 weeks.....				
Could you kneel down and get up afterwards?				
Yes, Easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, Impossible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past 4 weeks.....				
Have you been troubled by <u>pain from your knee</u> in bed at night?				
No nights	Only 1 or 2 nights	Some nights	Most nights	Every night
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past 4 weeks.....				
How much has <u>pain from your knee</u> interfered with your usual work? (including housework)				
Not at all	A little bit	Moderately	Greatly	Totally
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past 4 weeks.....				
Have you felt that your knee might suddenly “give way” or let you down?				
Rarely/ never	Sometimes, or just at first	Often, not just at first	Most of the time	All of the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past 4 weeks.....				
Could you do the household shopping <u>on your own</u>?				
Yes, Easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, Impossible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the past 4 weeks.....				
Could you walk down one flight of stairs?				
Yes, Easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, Impossible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please now hand this in to the doctor who is to see you

For administration only

Dated Patients Details Added Score = /48 (48 = best function)

Reported -10/+10 VAS improvement at 6/12 =

Please return to John Hardy, Chelsea Outpatient Centre, 280 Kings Road, London SW3 5AW.