

VALIDATED QUESTIONNAIRE

OXFORD KNEE QUESTIONNAIRE

When answering the questions please only consider how you have been getting on during the past four weeks

- | | Score | | Score |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--------------------------------------------------------------------------------------------------------------------------------------|-------|
| 1. How would you describe the pain you have usually from your left/right knee? | | 5. Have you been able to do your household shopping on your own? | |
| <input type="checkbox"/> None | 1 | <input type="checkbox"/> Yes, easily | 1 |
| <input type="checkbox"/> Very mild | 2 | <input type="checkbox"/> With little difficulty | 2 |
| <input type="checkbox"/> Mild | 3 | <input type="checkbox"/> With moderate difficulty | 3 |
| <input type="checkbox"/> Mild Moderate | 4 | <input type="checkbox"/> With extreme difficulty | 4 |
| <input type="checkbox"/> Severe | 5 | <input type="checkbox"/> No, impossible | 5 |
| 2. Have you had any trouble with washing and drying yourself (all over) because of your left/right knee? | | 6. For how long have you been able to walk before the pain from your left/right knee became severe? (with or without a stick) | |
| <input type="checkbox"/> No trouble at all | 1 | <input type="checkbox"/> No pain, even after more than 30 minutes | 1 |
| <input type="checkbox"/> Very little trouble | 2 | <input type="checkbox"/> 16 to 30 minutes | 2 |
| <input type="checkbox"/> Moderate trouble | 3 | <input type="checkbox"/> 5 to 15 minutes | 3 |
| <input type="checkbox"/> Extreme difficulty | 4 | <input type="checkbox"/> Around the house only | 4 |
| <input type="checkbox"/> Impossible to do | 5 | <input type="checkbox"/> Unable to walk at all | 5 |
| 3. Have you had any trouble getting in and out of a car or using public transport because of your left/right knee? (whichever you tend to use) | | 7. Have you been able to walk down a flight of stairs? | |
| <input type="checkbox"/> No trouble at all | 1 | <input type="checkbox"/> Yes, easily | 1 |
| <input type="checkbox"/> Very little trouble | 2 | <input type="checkbox"/> With little difficulty | 2 |
| <input type="checkbox"/> Moderate trouble | 3 | <input type="checkbox"/> With moderate difficulty | 3 |
| <input type="checkbox"/> Extreme difficulty | 4 | <input type="checkbox"/> With extreme difficulty | 4 |
| <input type="checkbox"/> Impossible to do | 5 | <input type="checkbox"/> No, impossible | 5 |
| 4. If you were to kneel down could you stand up afterwards? | | 8. After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your left/right knee? | |
| <input type="checkbox"/> Yes, easily | 1 | <input type="checkbox"/> Not at all painful | 1 |
| <input type="checkbox"/> With little difficulty | 2 | <input type="checkbox"/> Slightly painful | 2 |
| <input type="checkbox"/> With moderate difficulty | 3 | <input type="checkbox"/> Moderately painful | 3 |
| <input type="checkbox"/> With extreme difficulty | 4 | <input type="checkbox"/> Very painful | 4 |
| <input type="checkbox"/> No, impossible | 5 | <input type="checkbox"/> Unbearable | 5 |

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| 9. Have you been limping when walking, because of your left/right knee? | | 11. How much pain from your left/right knee interfered with your usual work (including housework)? | |
| <input type="checkbox"/> Rarely / never | 1 | <input type="checkbox"/> Not at all | 1 |
| <input type="checkbox"/> Sometimes or just at first | 2 | <input type="checkbox"/> A little bit | 2 |
| <input type="checkbox"/> Often, not just at first | 3 | <input type="checkbox"/> Moderately | 3 |
| <input type="checkbox"/> Most of the time | 4 | <input type="checkbox"/> Greatly | 4 |
| <input type="checkbox"/> All of the time | 5 | <input type="checkbox"/> Totally | 5 |
| 10. Have you felt that your right/left knee might suddenly "give way" or let you down? | | 12. Have you been troubled by pain from your left / right knee in bed at night? | |
| <input type="checkbox"/> Rarely / never | 1 | <input type="checkbox"/> No nights | 1 |
| <input type="checkbox"/> Sometimes or just at first | 2 | <input type="checkbox"/> Only 1 or 2 nights | 2 |
| <input type="checkbox"/> Often, not just at first | 3 | <input type="checkbox"/> Some nights | 3 |
| <input type="checkbox"/> Most of the time | 4 | <input type="checkbox"/> Most nights | 4 |
| <input type="checkbox"/> All of the time | 5 | <input type="checkbox"/> Every nights | 5 |