



Name: \_\_\_\_\_

MRN: \_\_\_\_\_ Date: \_\_\_\_\_

## Knee injury and osteoarthritis outcome score (KOOS)

Roos et al (1998) JOSPT 78, 88-96

### Pain

P 1 How often is your knee painful?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
<b>What degree of pain have you experienced the last week when...</b>					
P 2 Twisting / pivoting on your knee	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P 3 Straightening knee fully	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P 4 Bending knee fully	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P 5 Walking on flat surface	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P 6 Going up or down stairs	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P 7 At night while in bed	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P 8 Sitting or lying	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
P 9 Standing upright	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

### Symptoms

Sy 1 How severe is your knee stiffness after wakening in the morning?	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Sy 2 How severe is your knee stiffness after sitting, lying, or resting later in the day?	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Sy 3 Do you have swelling in your knee?	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
Sy 4 Do you feel grinding, hear clicking or any other type of noise when your knee moves?	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
Sy 5 Does your knee catch or hang up when moving?	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
Sy 6 Can you straighten your knee fully?	<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Sy 7 Can you bend your knee fully?	<input type="checkbox"/> Always	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never

### Activities of Daily Living

<b>What difficulty have you experienced the last week?</b>					
A 1 Descending stairs	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 2 Ascending stairs	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 3 Rising from sitting	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 4 Standing	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 5 Bending to floor / pick up an object	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 6 Walking on flat surface	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 7 Getting in / out of car	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 8 Going shopping	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 9 Putting on socks/stockings	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 10 Rising from bed	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 11 Taking off socks/stockings	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

### Activities of daily living (cont.)

A 12 Lying in bed (turning over, maintaining knee position)	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 13 Getting in / out of bath	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 14 Sitting	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 15 Getting on / off toilet	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 16 Heavy domestic duties (shoveling, scrubbing floors, etc.)	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A 17 Light domestic duties (cooking, dusting, etc.)	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

### Sport and Recreation Function

What difficulty have you experienced the last week...?					
Sp 1 Squatting	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Sp 2 Running	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Sp 3 Jumping	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Sp 4 Turning/misting on your injured knee	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
Sp 5 Kneeling	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

### Knee-Related Quality of Life

What difficulty have you experienced the last week...?					
Q 1 How often are you aware of your knee problems?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
Q 2 Have you modified your lifestyle to avoid potentially damaging activities to your knee?	<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely	<input type="checkbox"/> Totally
Q 3 How troubled are you with lack of confidence in your knee?	<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely	<input type="checkbox"/> Totally
Q 4 In general, how much difficulty do you have with your knee?	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

### Scoring:

Each item is scored 0 to 4 and the raw score for each section is the sum of item scores.

Scores are then transformed to a 0 to 100 scale. A higher score indicates fewer problems.

Scale	Raw Score	Transformed Score	MDC <sub>90</sub>
Pain	/ 36	$100 - \frac{\text{Actual raw score} \times 100}{\text{Possible raw score range}}$ <p>Example: a pain raw score of 16 would be transformed as follows:</p> $100 - \frac{(16 \times 100)}{36} = 56$	12 points
Symptoms	/ 28		8 points
ADL	/ 68		10 points
Sport / Rec	/ 20		19 points
QOL	/ 16		13 points