Patient Name:________________________________ Date:_____________

# WOMAC KNEE

This survey asks for your view about your knee. This information will help to keep track of how you feel about your knee and how well you are able to do your usual activities. Answer every question by circling the appropriate response. **If you are unsure about how to answer a question, please give the best answer you can.**

| These questions should be answered thinking of your **knee symptoms** during the **last week**. | **Never** | **Rarely** | **Sometimes** | **Often** | **Always** |
|---|---|---|---|---|---|
| 1. Do you have swelling in your knee? | 0 | 1 | 2 | 3 | 4 |
| 2. Do you feel grinding, hear clicking or any other type of noise when your knee moves? | 0 | 1 | 2 | 3 | 4 |
| 3. Does your knee catch or hang up when moving? | 0 | 1 | 2 | 3 | 4 |
| 4. Can you straighten your knee fully? | 4 | 3 | 2 | 1 | 0 |
| 5. Can you bend your knee fully? | 4 | 3 | 2 | 1 | 0 |
| 6. How severe is your knee joint stiffness after first waking in the morning? | 0 | 1 | 2 | 3 | 4 |
| 7. How severe is your knee stiffness after sitting, lying or resting **later in the day**? | 0 | 1 | 2 | 3 | 4 |
| 8. How often do you experience knee pain? | 0 | 1 | 2 | 3 | 4 |

| What **amount of pain** have you experienced the **last week** during the following activities. | **None** | **Mild** | **Moderate** | **Severe** | **Extreme** |
|---|---|---|---|---|---|
| 1. Twisting/Pivoting | 0 | 1 | 2 | 3 | 4 |
| 2. Straightening knee fully | 0 | 1 | 2 | 3 | 4 |
| 3. Bending knee fully | 0 | 1 | 2 | 3 | 4 |
| 4. Walking on Flat surface | 0 | 1 | 2 | 3 | 4 |
| 5. Going up or down stairs | 0 | 1 | 2 | 3 | 4 |
| 6. At night while in bed | 0 | 1 | 2 | 3 | 4 |
| 7. Sitting or lying | 0 | 1 | 2 | 3 | 4 |
| 8. Standing upright | 0 | 1 | 2 | 3 | 4 |

| For each of the following activities please indicate the **degree of difficulty** you have experienced in the **last week** due to your knee. | **None** | **Mild** | **Moderate** | **Severe** | **Extreme** |
|---|---|---|---|---|---|
| 1. Descending stairs | 0 | 1 | 2 | 3 | 4 |
| 2. Ascending stairs | 0 | 1 | 2 | 3 | 4 |
| 3. Rising from sitting | 0 | 1 | 2 | 3 | 4 |
| 4. Standing | 0 | 1 | 2 | 3 | 4 |
| 5. Bending to floor/pick up an object | 0 | 1 | 2 | 3 | 4 |
| 6. Walking on flat surface | 0 | 1 | 2 | 3 | 4 |
| 7. Getting in/out of car | 0 | 1 | 2 | 3 | 4 |
| 8. Going Shopping | 0 | 1 | 2 | 3 | 4 |
| 9. Putting on socks/stockings | 0 | 1 | 2 | 3 | 4 |
| 10. Rising from bed | 0 | 1 | 2 | 3 | 4 |
| 11. Taking off socks/stockings | 0 | 1 | 2 | 3 | 4 |
| 12. Lying in bed (turning over, maintaining knee position) | 0 | 1 | 2 | 3 | 4 |
| 13. Getting in/out of bath | 0 | 1 | 2 | 3 | 4 |
| 14. Sitting | 0 | 1 | 2 | 3 | 4 |
| 15. Getting on/off toilet | 0 | 1 | 2 | 3 | 4 |
| 16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc) | 0 | 1 | 2 | 3 | 4 |
| 17. Light domestic duties (cooking, dusting, etc) | 0 | 1 | 2 | 3 | 4 |