

Baseline Questionnaire Pack

Participants Screening Number:

X	X	X	X
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Initials:

X	X	X
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Please answer every question. It is important that we collect as much information as possible. If a question can't be completed, please let the researchers know or write down why on the questionnaire.

If you have any questions about how to fill in any of the questionnaires, please ask the researcher and they will try to help.

Please return the completed pack to the researcher who issued it to you.

Thank you very much for answering the questions.

Date Completed: __ __ / __ __ __ / __ __ __ __

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X

X

The following questions are related to your general health

Please **circle** the response that applies to you

1. Have you ever had a heart attack?	YES/NO
2. Have you ever been treated for heart failure? (You may have been short of breath and the doctor may have told you that you had fluid in your lungs or that your heart was not pumping well.)	YES/NO
3. Have you had an operation to unclog or bypass the arteries in your legs?	YES/NO
4. Have you had a stroke, cerebrovascular accident (CVA), blood clot or bleeding in the brain or transient ischemic attack (TIA)?	YES/NO
4a. If YES , Do you have difficulty moving an arm or leg as a result of the stroke or cerebrovascular accident?	YES/NO
5. Do you have asthma?	YES/NO
If YES , do you take medicines for your asthma? a. no b. yes, only with flare-ups of my asthma c. Yes, I take medicines regularly, even when I'm not having a flare up	A/B/C
6. Do you have emphysema, chronic bronchitis, or chronic obstructive lung disease?	YES/NO
If yes , do you take medicine for your lung disease? a. no b. yes, only with flare-ups of my lung disease c. Yes, I take medicines regularly, even when I'm not having a flare up	A/B/C
7. Do you have stomach ulcers, or peptic ulcer disease?	YES/NO
If yes , has this condition been diagnosed by endoscopy (where a doctor looks into your stomach through a scope) or an upper GI or barium swallow study (where you swallow chalky dye and then x-rays are taken)?	YES/NO

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8. Do you have diabetes (high blood sugar)?	YES/NO
If yes , is your diabetes treated by a. modifying my diet b. medications taken by mouth c. insulin injections	A/B/C
has the diabetes caused any of the following problems a. problems with your kidneys b. problems with your eyes, treated by an ophthalmologist	A/B
9. Have you ever had the following problems with your kidneys?	YES/NO
A. Poor kidney function (blood tests show high creatinine)	
B. Have used hemodialysis or peritoneal dialysis	
C. Have received kidney transplantation	A/B/C
10. Do you have rheumatoid arthritis?	YES/NO
If yes do you take medications for it regularly?	YES/NO
Do you have Lupus (systemic lupus erythematosus)?	YES/NO
Do you have Polymyalgia rheumatica?	YES/NO
11. Do you have any of the following conditions:	
i) Alzheimer's disease or any other form of dementia	YES/NO
ii) Cirrhosis, or serious liver damage	YES/NO
iii) Leukemia or polycythemia vera	YES/NO
iv) Lymphoma	YES/NO
v) Cancer, other than skin cancer, leukaemia or lymphoma?	YES/NO
If yes has this been present for more than 5 years?	YES/NO
Has the cancer spread, or metastasized to other parts of your body?	YES/NO
vi) AIDs	YES/NO
Do you have any other joint problems? If yes , please provide details	YES/NO

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LLFDI.

Please use the prompts in the research clinician folder.

Function Component:

How much difficulty do you have doing:	None	A little	Some	Quite a lot	Cannot do
F1. Unscrewing the lid off a previously unopened jar without using any devices					
F2. Going up & down a flight of stairs, using a handrail					
F3. Putting on and taking off long pants (including managing fasteners)					
F4. Running 1/2 mile or more					
F5. Using common utensils for preparing meals (e.g., Can opener, potato peeler or sharp knife)					
F6. Holding a full glass of water in one hand					
F7. Walking a mile, taking rests as necessary					
F8. Going up and down a flight of stairs outside, without using a handrail					
F9. Running a short distance, such as to catch a bus					
F10. Reaching overhead while standing, as if to pull a light cord.					
F11. Sitting down in and standing up from a low, soft couch.					
F12. Putting on and taking off a coat or jacket					
F13. Reaching behind your back as if to put a belt through a belt loop.					
F14. Stepping up and down from a curb.					
F15. Opening a heavy, outside door					
F16. Rip open a package of Snack food					
F17. Pouring from a large pitcher					
F18. Getting into and out of a car/taxi					

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	None	A little	Some	Quite a lot	Cannot do
F19. Hiking a couple of miles on uneven surfaces, including hills					
F20. Going up and down 3 flights of stairs inside, using a handrail					
F21. Picking up a kitchen chair and moving it, in order to clean					
F22. Using a step stool to reach into a high cabinet					
F23. Making a bed, Including spreading and tucking in bed sheets					
F24. Carrying something in both arms while climbing a flight of stairs (e.g. a laundry basket)					
F25. Bending over from a standing position to pick up a piece of clothing from the floor					
F26. Walking around one floor of your home.					
F27. Getting up from the floor					
F28. Washing dishes, pots and utensils by hand whilst standing at the sink.					
F29. Walking several Blocks					
F30. Taking a 1 mile brisk walk without stopping to rest.					
F31. Stepping on and off a bus					
F32. Walking on a slippery surface outdoors					

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FOR THOSE WHO USE WALKING DEVICES

When you use your cane, walker or other walking device, how much difficulty do you have.....?

	None	A little	Some	Quite a lot	Cannot do
FD7. Walking a mile, taking rests as necessary					
FD8. Going up & down a flight of stairs outside, without using a handrail.					
FD14. Stepping up and down from a curb					
FD15. Opening a heavy, outside door					
FD26. Walking around one floor of your home					
FD29. Walking several Blocks					
FD30. Taking a 1 mile brisk walk without stopping to rest.					
FD32. Walking on a slippery surface, outdoors					

Disability Component

How often do you:	Very often	Often	Once in a while	Almost Never	Never
D1. Keep in touch with others through letters, phone or email.					
D2. Visit friends and family in their homes					
D3. Provide care or assistance to Others					
D4. Take care of the inside of your home					
D5. Work at a volunteer job outside your home					
D6. Take part in active recreation					
D7. Take care of household business and finances					
D8. Take care of your own health					
D9. Travel out of town for at least an overnight stay					

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	Very often	Often	Once in a while	Almost Never	Never
D10. Take part in regular fitness program					
D11. Invite people into your home for entertainment					
D12. Go out with others to public places such as restaurants or movies					
D13. Take care of your own personal care needs					
D14. Take part in organised social activities					
D15. Take care of local errands					
D16. Prepare meals for yourself					

To what extent do you feel limited in?	Not at all	A little	Somewhat	A lot	Completely
D1. Keeping in touch with others through letters, phone or email.					
D2. Visiting friends and family in their homes					
D3. Providing care or assistance to Others					
D4. Taking care of the inside of your home					
D5. Working at a volunteer job outside your home					
D6. Taking part in active recreation					
D7. Taking care of household business and finances					
D8. Taking care of your own health					

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	Not at all	A little	Somewhat	A lot	Completely
D9. Travelling out of town for at least an overnight stay					
D10. Taking part in regular fitness program					
D11. Inviting people into your home for entertainment					
D12. Going out with others to public places such as restaurants or movies					
D13. Taking care of your own personal care needs					
D14. Taking part in organised social activities					
D15. Taking care of local errands					
D16. Preparing meals for yourself					

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Oxford Knee Score

Please answer the following 12 multiple choice questions. Tick **ONE** box for every question

During the past 4 weeks.....

1. How would you describe the pain you usually have in your knee?

- ☐ None
- ☐ Very mild
- ☐ Mild
- ☐ Moderate
- ☐ Severe

2. Have you had any trouble washing and drying yourself (all over) because of your knee?

- ☐ No trouble at all
- ☐ Very little trouble
- ☐ Moderate trouble
- ☐ Extreme difficulty
- ☐ Impossible to do so

3. Have you had any trouble getting in and out of the car or using public transport because of your knee? (with or without a stick)

- ☐ No trouble at all
- ☐ Very little trouble
- ☐ Moderate trouble
- ☐ Extreme difficulty
- ☐ Impossible to do

4. For how long are you able to walk before the pain in your knee becomes severe? (with or without a stick)

- ☐ No pain > 30 mins
- ☐ 16 – 30 minutes
- ☐ 5 – 15 minutes
- ☐ Around the house only
- ☐ Not at all – Pain severe on walking

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5. After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your knee?

- ☐ Not painful at all
- ☐ Slightly painful
- ☐ Moderately pain
- ☐ Very painful
- ☐ Unbearable

6. Have you been limping when walking, because of your knee?

- ☐ Rarely / never
- ☐ Sometimes or just at first
- ☐ Often, not just at first
- ☐ Most of the time
- ☐ All of the time

7. Could you kneel down and get up again afterwards?

- ☐ Yes, easily
- ☐ With little difficulty
- ☐ With moderate difficulty
- ☐ With extreme difficulty
- ☐ No, impossible

8. Are you troubled by pain in your knee at night in bed?

- ☐ Not at all
- ☐ Only one or two nights
- ☐ Some nights
- ☐ Most nights
- ☐ Every night

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9. How much has pain from your knee interfered with your usual work? (including housework)

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Greatly
- ☐ Totally

10. 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

11. Can you do household shopping on your own?

- ☐ Yes, easily
- ☐ With little difficulty
- ☐ With moderate difficulty
- ☐ With extreme difficulty
- ☐ No, impossible

12. Could you walk down a flight of stairs?

- ☐ Yes, easily
- ☐ With little difficulty
- ☐ With moderate difficulty
- ☐ With extreme difficulty
- ☐ No, impossible

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PASE

LEISURE TIME ACTIVITY

1. Over the past 7 days, how often did you participate in sitting activities such as reading, watching TV or doing handcrafts?

☐

Never



**Go
to
next
Q**

☐

Seldom
(1-2
days)



What were these activities?

☐

Sometimes
(3-4 days)


☐

Often
(5-7
days)



On average, how many hours per day did you engage in these sitting activities?

☐

Less
than 1
hour

☐

1 but less
than 2 hours

☐

2-4 hours

☐

More than
4 hours

2. Over the past 7 days, how often did you take a walk outside your home or yard for any reason? For example, for fun or exercise, walking to work, walking the dog, etc.?

☐

Never



**Go
to
next
Q**

☐

Seldom
(1-2
days)



On average, how many hours per day did you spend walking?

☐

Sometimes
(3-4 days)


☐

Often
(5-7
days)


☐

Less
than 1
hour

☐

1 but less
than 2 hours

☐

2-4 hours

☐

More than
4 hours

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3. Over the past 7 days, how often did you engage in light sport and recreational activities such as bowling, golf with a cart, shuffleboard, fishing from a boat or pier or other similar activities?

☐

Never



**Go
to
next
Q**

☐

Seldom
(1-2
days)



What were these activities?

☐

Sometimes
(3-4 days)


☐

Often
(5-7
days)



On average, how many hours per day did you engage in these light sport or recreational activities?

☐

Less
than 1
hour

☐

1 but less
than 2 hours

☐

2-4 hours

☐

More than
4 hours

4. Over the past 7 days, how often did you engage in moderate sport and recreational activities such as doubles tennis, ballroom dancing, hunting, ice skating, golf without a cart, softball or other similar activities?

☐

Never



**Go
to
next
Q**

☐

Seldom
(1-2
days)



What were these activities?

☐

Sometimes
(3-4 days)


☐

Often
(5-7
days)



On average, how many hours per day did you engage in these moderate sport or recreational activities?

☐

Less
than 1
hour

☐

1 but less
than 2 hours

☐

2-4 hours

☐

More than
4 hours

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5. Over the past 7 days, how often did you engage in strenuous sport and recreational activities such as jogging, swimming, cycling, singles tennis, aerobic dance, skiing (downhill or cross-country) or other similar activities?

☐

Never



**Go
to
next
Q**

☐

Seldom
(1-2
days)



What were these activities?

☐

Sometimes
(3-4 days)


☐

Often
(5-7
days)



On average, how many hours per day did you engage in these strenuous sport and recreational activities?

☐

Less
than 1
hour

☐

1 but less
than 2 hours

☐

2-4 hours

☐

More than
4 hours

6. Over the past 7 days, how often did you do any exercises specifically to increase muscle strength and endurance, such as lifting weights or pushups, etc.?

☐

Never



**Go
to
next
Q**

☐

Seldom
(1-2 days)



What were these activities?

☐

Sometimes
(3-4 days)


☐

Often
(5-7
days)



On average, how many hours per day did you engage in exercises to increase muscle strength and endurance?

☐

Less
than 1
hour

☐

1 but less
than 2 hours

☐

2-4 hours

☐

More than
4 hours

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HOUSEHOLD ACTIVITY

7. During the past 7 days, have you done any light housework, such as dusting or washing dishes?

☐ Yes

☐ No

8. During the past 7 days, have you done any heavy housework or chores, such as vacuuming, scrubbing floors, washing windows, or carrying wood?

☐ Yes

☐ No

9. During the past 7 days, did you engage in any of the following activities?

Please answer YES or NO for each item.

Home repairs like painting, wallpapering, electrical work, etc.

☐ Yes

☐ No

Lawn work or yard care, including snow or leaf removal, chopping wood, etc.

☐ Yes

☐ No

Outdoor gardening

☐ Yes

☐ No

Caring for another person such as children, dependent spouse, or another adult

☐ Yes

☐ No

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WORK-RELATED ACTIVITY

10. During the past 7 days, did you work for pay or as a volunteer?

☐

Yes

☐

No



How many hours per week did you work for pay and / or as a volunteer? _____ Hours

Which of the following categories best describes the amount of physical activity required on your job and/or volunteer work?

[1] Mainly sitting with slight arm movements.
Examples: office worker, watchmaker, seated assembly line worker, bus driver, etc.

☐

[2] Sitting or standing with some walking.
Examples: cashier, general office worker, light tool and machinery worker.

☐

[3] Walking, with some handling of materials generally weighing less than 50 pounds.
Examples: mailman, waiter/waitress, construction worker, heavy tool and machinery worker.

☐

[4] Walking and heavy manual work often requiring handling of materials weighing over 50 pounds. Examples: lumberjack, stone mason, farm or general labourer.

☐

Thank you for taking the time and effort to complete this questionnaire!

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X	X	X
---	---	---

EQ5D

Under each heading, please tick the **ONE** box that best describes your health **TODAY**

Mobility

- I have no problems in walking about ☐
- I have slight problems in walking about ☐
- I have moderate problems in walking about ☐
- I have severe problems in walking about ☐
- I am unable to walk about ☐

Self-care

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

Usual Activities (e.g. work, study, housework, family of leisure activities)

- I have no problems doing my usual activities ☐
- I have slight problems doing my usual activities ☐
- I have moderate problems doing my usual activities ☐
- I have severe problems doing my usual activities ☐
- I am unable to do my usual activities ☐

Pain / Discomfort

- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

Anxiety / Depression

- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

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X	X	X
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We would like to know how good or bad your health is TODAY.

This scale is numbered from 0 to 100.

100 means the best health you can imagine.

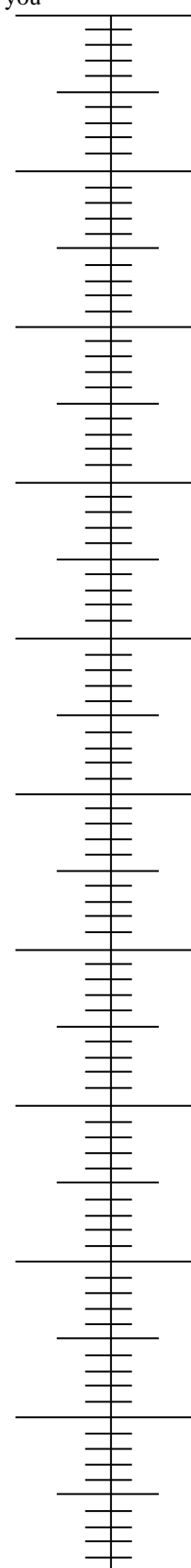
0 means the worst health you can imagine.

Mark an X on the scale to indicate how your health is TODAY.

Now, **please write the number you marked on the scale in the box below.**

YOUR HEALTH TODAY =

The best health you
can imagine



100

95

90

85

80

75

70

65

60

55

50

45

40

35

30

25

20

15

10

5

0

The worst health you
can imagine

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Knee injury and Osteoarthritis Outcome Score (KOOS) – Quality of life subscale

Q1. How often are you aware of your knee problem?

Never

☐

Monthly

☐

Weekly

☐

Daily

☐

Constantly

☐

Q2. Have you modified your life style to avoid potentially damaging activities to your knee?

Not at all

☐

Mildly

☐

Moderately

☐

Severely

☐

Totally

☐

Q3. How much are you troubled with lack of confidence in your knee?

Not at all

☐

Mildly

☐

Moderately

☐

Severely

☐

Extremely

☐

Q4. In general how much difficulty do you have with your knee?

None

☐

Mild

☐

Moderate

☐

Severe

☐

Extreme

☐