Draft

Prospective Cohort
Initial Form (Patient, Child)

Subject ID ☐☐ - ☐☐☐ - ☐

Please use black pen only to complete the form. Thank you

Today's Date

☐☐ / ☐☐ / ☐☐☐☐

Month Day Year

Surgeon ID ☐☐☐

Site Number ☐☐☐

First Name

Last Name

Home Address (Number and Street)

Home Address (Apt. #)

City

State ☐☐

Zip Code ☐☐☐☐☐

Primary Phone Number

(☐☐☐) ☐☐☐ - ☐☐☐☐

Secondary Phone Number

(☐☐☐) ☐☐☐ - ☐☐☐☐

Email Address

Sex ○ Female ○ Male

Age ☐☐☐

Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Height (inches) ☐☐

Weight (lbs) ☐☐☐

Race

○ White
○ Black or African American
○ Asian
○ American Indian or Native Alaskan
○ Native Hawaiian or Pacific Islander
○ Prefer not to answer
○ Other, specify_____

Are you Hispanic or Latino?

○ Yes
○ No
○ Prefer not to answer

SSN (optional - for follow-up purposes only)

☐☐☐ - ☐☐ - ☐☐☐☐

Draft

Prospective Cohort
Initial Form (Patient, Child)

Subject ID ☐☐ - ☐☐☐ - ☐

Date of Visit
☐☐ / ☐☐ / ☐☐☐☐
Month Day Year

Study Visit:
● Baseline

KNEE

Has anyone in your birth family had osteochondritis dissecans? Check all that apply.

O No
O Don't know
O Mother
O Father
O Sister(s)
O Brother(s)
O Grandmother(s)
O Grandfather(s)

Have you been diagnosed with an OCD lesion in any joint before?
O Yes O No

If yes, which joint?
O Other Knee O Shoulder O Elbow O Hip O Ankle

Are you experiencing knee pain?
O Yes - Left O Yes - Right
O No - Left O No - Right

If yes, how long have you been experiencing knee pain, in months? ☐☐☐

If yes, did your knee pain start immediately following a knee injury?
O Yes O No

Have you received treatment from anyone for your knee pain?
O Yes O No

If yes, how many people have you seen? ☐☐

If yes, who have you seen?
O Athletic Trainer
O Physical Therapist
O Chiropractor
O Primary Care Physician
O Primary Care Sports Medicine Physician
O Orthopaedic Surgeon
O Other

Prospective Cohort
Initial Form (Patient, Child)

Subject ID ☐☐ - ☐☐☐ - ☐

Pedi-IKDC SUBJECTIVE KNEE EVALUATION FORM

SYMPTOMS*:

1. What is the most you could do today without making your injured knee hurt a lot?

O Very hard activities like jumping or turning fast to change direction, like in basketball or soccer

O Hard activities like heavy lifting, skiing or tennis

O Sort of hard activities like walking fast or jogging

O Light activities like walking at a normal speed

O I can't do any of the activities listed above because my knee hurts too much now

2. During the past 4 weeks, or since your injury, how much of the time did your injured knee hurt?

O 0 (Never) O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 (Hurt all the time)

3. How badly does your injured knee hurt today?

O 0 (No hurt at all) O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 (Hurts so much I can't stand it)

4. During the past 4 weeks, or since your injury, how hard has it been to move or bend your injured knee?

O Not at all hard O A little hard O Somewhat hard O Very hard O Extremely hard

5. During the past 4 weeks, or since your injury, how puffy (or swollen) was your injured knee?

O Not at all puffy

O A little puffy

O Somewhat puffy

O Very puffy

O Extremely puffy

6. What is the most you could do today without making your injured knee puffy (or swollen)?

O Very hard activities like jumping or turning fast to change direction, like in basketball or soccer

O Hard activities like heavy lifting, skiing or tennis

O Sort of hard activities like walking fast or jogging

O Light activities like walking at a normal speed

O I can't do any of the activities listed above because my injured knee is puffy even when I rest

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7. During the past 4 weeks, or since your injury, did your knee ever get stuck in place (lock) so you could not move it?

O Yes

O No

8. During the past 4 weeks, or since your injury, did your knee ever feel like it was getting stuck (catching) but you could still move it?

O Yes

O No

9. What is the most you could do today without your knee feeling like it can't hold you up?

O Very hard activities like jumping or turning fast to change direction, like in basketball or soccer

O Hard activities like heavy lifting, skiing or tennis

O Sort of hard activities like walking fast or jogging

O Light activities like walking at a normal speed

O I can't do any of the activities listed above because my injured knee is puffy even when I rest

SPORTS ACTIVITIES:

10. What is the most you can do on your injured knee most of the time?

O Very hard activities like jumping or turning fast to change direction, like in basketball or soccer

O Hard activities like heavy lifting, skiing or tennis

O Sort of hard activities like walking fast or jogging

O Light activities like walking at a normal speed

O I can't do any of the activities listed above because my injured knee is puffy even when I rest

11. Does your injured knee affect your ability to:	No, not at all	Yes, a little	Yes, somewhat	Yes, a lot	I can't do this
a. Go up stairs?	O	O	O	O	O
b. Go down stairs?	O	O	O	O	O
c. Kneel on your injured knee?	O	O	O	O	O
d. Squat down like a baseball catcher?	O	O	O	O	O
e. Sit in a chair with your knees bent and feet flat on the floor?	O	O	O	O	O
f. Get up from a chair?	O	O	O	O	O
g. Run?	O	O	O	O	O
h. Jump and land on your injured knee?	O	O	O	O	O
i. Stop and start moving quickly?	O	O	O	O	O

12. How well did your knee work before you injured it?

0	1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O	O

I could not do anything at all — I could do anything I wanted to

13. How well does your knee work now?

0	1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O	O

I am not able to do anything at all — I am able to do anything I want to do

14. Who completed the questionnaire? O Child alone O Child with help from parent/adult

KOOS KNEE SURVEY

INSTRUCTIONS: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to perform your usual activities.

Answer every question by filling in the appropriate bubble, only one bubble for each question. If you are unsure about how to answer a question, please give the best answer you can.

Symptoms:
These questions should be answered thinking of your knee symptoms during the **last week.**

S1. Do you ever have swelling in your knee?
O Never O Rarely O Sometimes O Often O Always

S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?
O Never O Rarely O Sometimes O Often O Always

S3. Does your knee ever catch or hang up when moving?
O Never O Rarely O Sometimes O Often O Always

S4. Can you straighten your knee fully?
O Always O Often O Sometimes O Rarely O Never

S5. Can you bend your knee fully?
O Always O Often O Sometimes O Rarely O Never

Prospective Cohort
Initial Form (Patient, Child)

Subject ID ☐☐ - ☐☐☐ - ☐

Stiffness:

The following questions concern the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

S6. How severe is your knee joint stiffness after first waking in the morning?

O None O Mild O Moderate O Severe O Extreme

S7. How severe is your knee stiffness after sitting, lying or resting later in the day?

O None O Mild O Moderate O Severe O Extreme

Pain:

P1. How often do you experience knee pain?

O Never O Monthly O Weekly O Daily O Always

What amount of knee pain have you experienced the **last week** during the following activities?

P2. Twisting/pivoting on your knee

O None O Mild O Moderate O Severe O Extreme

P3. Straightening knee fully

O None O Mild O Moderate O Severe O Extreme

P4. Bending knee fully

O None O Mild O Moderate O Severe O Extreme

P5. Walking on flat surface

O None O Mild O Moderate O Severe O Extreme

P6. Going up or down stairs

O None O Mild O Moderate O Severe O Extreme

P7. At night while in bed

O None O Mild O Moderate O Severe O Extreme

P8. Sitting or lying

O None O Mild O Moderate O Severe O Extreme

P9. Standing upright

O None O Mild O Moderate O Severe O Extreme

Prospective Cohort
Initial Form (Patient, Child)

Subject ID ☐☐ - ☐☐☐ - ☐

Function, daily living:
The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A1. Descending stairs
O None O Mild O Moderate O Severe O Extreme

A2. Ascending stairs
O None O Mild O Moderate O Severe O Extreme

A3. Rising from sitting
O None O Mild O Moderate O Severe O Extreme

A4. Standing
O None O Mild O Moderate O Severe O Extreme

A5. Bending to floor/pick up an object
O None O Mild O Moderate O Severe O Extreme

A6. Walking on flat surface
O None O Mild O Moderate O Severe O Extreme

A7. Getting in/out of car
O None O Mild O Moderate O Severe O Extreme

A8. Going shopping
O None O Mild O Moderate O Severe O Extreme

A9. Putting on socks/stockings
O None O Mild O Moderate O Severe O Extreme

A10. Rising from bed
O None O Mild O Moderate O Severe O Extreme

A11. Taking off socks/stockings
O None O Mild O Moderate O Severe O Extreme

A12. Lying in bed (turning over, maintaining knee position)
O None O Mild O Moderate O Severe O Extreme

Prospective Cohort
Initial Form (Patient, Child)

Subject ID ☐☐ - ☐☐☐ - ☐

For each of the following activities, please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A13. Getting in/out of bath
O None O Mild O Moderate O Severe O Extreme

A14. Sitting
O None O Mild O Moderate O Severe O Extreme

A15. Getting on/off toilet
O None O Mild O Moderate O Severe O Extreme

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)
O None O Mild O Moderate O Severe O Extreme

A17. Light domestic duties (cooking, dusting, etc)
O None O Mild O Moderate O Severe O Extreme

Function, sports and recreational activities:
The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your knee.

SP1. Squatting
O None O Mild O Moderate O Severe O Extreme

SP2. Running
O None O Mild O Moderate O Severe O Extreme

SP3. Jumping
O None O Mild O Moderate O Severe O Extreme

SP4. Twisting/pivoting on your injured knee
O None O Mild O Moderate O Severe O Extreme

SP5. Kneeling
O None O Mild O Moderate O Severe O Extreme

Draft

Prospective Cohort
Initial Form (Patient, Child)

Subject ID ☐☐ - ☐☐☐ - ☐

Quality of life:

Q1. How often are you aware of your knee problem?
O Never O Monthly O Weekly O Daily O Constantly

Q2. Have your modified your life style to avoid potentially damaging activities to your knee?
O Not at all O Mildly O Moderately O Severely O Totally

Q3. How much are you troubled with lack of confidence in your knee?
O Not at all O Mildly O Moderately O Severely O Extremely

Q4. In general, how much difficulty do you have with your knee?
O None O Mild O Moderate O Severe O Extreme

Subject ID

[ ][ ] - [ ][ ][ ] - [ ]

FABS SCALE

Please indicate how often you performed each activity **in your healthiest and most active state, in the past year.**

	Less than one time in a month 0	One time in a month 1	One time in a week 2	2 or 3 times in a week 3	4 or more times in a week 4
Running: while playing a sport or jogging	O	O	O	O	O
Cutting: changing directions while running	O	O	O	O	O
Deceleration: coming to a quick stop while running	O	O	O	O	O
Pivoting: turning your body with your foot planted while playing sport; For example: skiing, skating, kicking, throwing, hitting a ball (golf, tennis, squash), etc.	O	O	O	O	O
Duration: perform athletic activity for as long as you would like to without stopping	O	O	O	O	O
Endurance: perform athletic activity for one whole hour without stopping	O	O	O	O	O

Competition: Do you participate in organized competitive sports or physical activities?

O No (or gym class only)

O Yes, but WITHOUT an official or judge (such as club or pickup games)

O Yes, WITH an official or judge

O Yes, at a national or professional level

Supervision: Do you participate in supervised sports practice or activities (other than gym class)?

O No

O Yes, 1-2 times per week

O Yes, 3-4 times per week

O Yes, 5 or more times per week

Draft

Prospective Cohort
Initial Form (Patient)

Subject ID ☐☐ - ☐☐☐ - ☐

Please use black pen only to complete the form. Thank you

Today's Date ☐☐ / ☐☐ / ☐☐☐☐
Month Day Year

Surgeon ID ☐☐☐ **Site Number** ☐☐☐

First Name

Last Name

Home Address (Number and Street)

Home Address (Apt. #)

City

State ☐☐ **Zip Code** ☐☐☐☐☐

Primary Phone Number (☐☐☐) ☐☐☐ - ☐☐☐☐

Secondary Phone Number (☐☐☐) ☐☐☐ - ☐☐☐☐

Email Address

Sex ○ Female ○ Male

Age ☐☐☐ **Date of Birth** ☐☐ / ☐☐ / ☐☐☐☐

Height (inches) ☐☐ **Weight (lbs)** ☐☐☐

Race
- ○ White
- ○ Black or African American
- ○ Asian
- ○ American Indian or Native Alaskan
- ○ Native Hawaiian or Pacific Islander
- ○ Prefer not to answer
- ○ Other, specify_____

Are you Hispanic or Latino?
- ○ Yes
- ○ No
- ○ Prefer not to answer

SSN (optional - for follow-up purposes only) ☐☐☐ - ☐☐ - ☐☐☐☐

Draft

Prospective Cohort
Initial Form (Patient)

Subject ID ☐☐ - ☐☐☐ - ☐

Date of Visit
☐☐ / ☐☐ / ☐☐☐☐
Month Day Year

Study Visit:
● Baseline

KNEE

Has anyone in your birth family had osteochondritis dissecans? Check all that apply.

O No
O Don't know
O Mother
O Father
O Sister(s)
O Brother(s)
O Grandmother(s)
O Grandfather(s)

Have you been diagnosed with an OCD lesion in any joint before?
O Yes O No

If yes, which joint?
O Other Knee O Shoulder O Elbow O Hip O Ankle

Are you experiencing knee pain?
O Yes - Left O Yes - Right
O No - Left O No - Right

If yes, how long have you been experiencing knee pain, in months? ☐☐☐

If yes, did your knee pain start immediately following a knee injury?
O Yes O No

Have you received treatment from anyone for your knee pain?
O Yes O No

If yes, how many people have you seen? ☐☐

If yes, who have you seen?
O Athletic Trainer
O Physical Therapist
O Chiropractor
O Primary Care Physician
O Primary Care Sports Medicine Physician
O Orthopaedic Surgeon
O Other

Draft

Prospective Cohort
Initial Form (Patient)

Subject ID ☐☐ - ☐☐☐ - ☐

IKDC SUBJECTIVE KNEE EVALUATION FORM

SYMPTOMS*:

***Grade symptoms at the highest activity level at which you think you could function without significant symptoms, even if you are not actually performing activites at this level.**

1. What is the highest level of activity that you can perform without significant knee pain?

O Very strenuous activities like jumping or pivoting as in basketball or soccer

O Strenuous activities like heavy physical work, skiing or tennis

O Moderate activities like moderate physical work, running or jogging

O Light activities like walking, housework or yard work

O Unable to perform any of the above activities due to knee pain

2. During the past 4 weeks, or since your injury, how often have you had pain?

O 0 (Never) O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 (Constant)

3. If you have pain, how severe is it?

O 0 (No pain) O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 (Worst pain imaginable)

4. During the past 4 weeks, or since your injury, how stiff or swollen was your knee?

O Not at all O Mildly O Moderately O Very O Extremely

5. What is the highest level of activity you can perform without significant swelling in your knee?

O Very strenuous activities like jumping or pivoting as in basketball or soccer

O Strenuous activities like heavy physical work, skiing or tennis

O Moderate activities like moderate physical work, running or jogging

O Light activities like walking, housework, or yard work

O Unable to perform any of the above activities due to knee swelling

6. During the past 4 weeks, or since your injury, did your knee lock or catch?

O Yes

O No

Prospective Cohort
Initial Form (Patient)

Subject ID ☐☐ - ☐☐☐ - ☐

7. What is the highest level of activity you can perform without significant giving way in your knee?

O Very strenuous activities like jumping or pivoting as in basketball or soccer
O Strenuous activities like heavy physical work, skiing or tennis
O Moderate activities like moderate physical work, running or jogging
O Light activities like walking, housework or yard work
O Unable to perform any of the above activities due to giving way of the knee

SPORTS ACTIVITIES:

8. What is the highest level of activity you can participate in on a regular basis?

O Very strenuous activities like jumping or pivoting as in basketball or soccer
O Strenuous activities like heavy physical work, skiing or tennis
O Moderate activities like moderate physical work, running or jogging
O Light activities like walking, housework or yard work
O Unable to perform any of the above activities due to knee

9. How does your knee affect your ability to:

	Not difficult at all	Minimally difficult	Moderately difficult	Extremely difficult	Unable to do
a. Go up stairs:	O	O	O	O	O
b. Go down stairs:	O	O	O	O	O
c. Kneel on the front of knee:	O	O	O	O	O
d. Squat:	O	O	O	O	O
e. Sit with your knee bent:	O	O	O	O	O
f. Rise from a chair:	O	O	O	O	O
g. Run straight ahead	O	O	O	O	O
h. Jump and land on involved leg:	O	O	O	O	O
i. Stop and start quickly:	O	O	O	O	O

Prospective Cohort
Initial Form (Patient)

Subject ID ☐☐ - ☐☐☐ - ☐

FUNCTION:

10. How would you rate the function of your knee on a scale of 0 to 10 with 10 being normal, excellent function and 0 being the inability to perform any of your usual daily activities which may include sports?

FUNCTION PRIOR TO YOUR KNEE INJURY:

0	1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O	O

Couldn't perform daily activities — No limitation in daily activities

CURRENT FUNCTION OF YOUR KNEE:

0	1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O	O

Can't perform daily activities — No limitation in daily activities

KOOS KNEE SURVEY

INSTRUCTIONS: This survey asks for your view about your knee. This information will help us keep track of how you feel about your knee and how well you are able to perform your usual activities.

Answer every question by filling in the appropriate bubble, only one bubble for each question. If you are unsure about how to answer a question, please give the best answer you can.

Symptoms:
These questions should be answered thinking of your knee symptoms during the **last week.**

S1. Do you ever have swelling in your knee?
O Never O Rarely O Sometimes O Often O Always

S2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?
O Never O Rarely O Sometimes O Often O Always

S3. Does your knee ever catch or hang up when moving?
O Never O Rarely O Sometimes O Often O Always

S4. Can you straighten your knee fully?
O Always O Often O Sometimes O Rarely O Never

S5. Can you bend your knee fully?
O Always O Often O Sometimes O Rarely O Never

Prospective Cohort Initial Form (Patient)

Subject ID [ ][ ] - [ ][ ][ ] - [ ]

Stiffness:

The following questions concern the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

S6. How severe is your knee joint stiffness after first waking in the morning?

O None O Mild O Moderate O Severe O Extreme

S7. How severe is your knee stiffness after sitting, lying or resting later in the day?

O None O Mild O Moderate O Severe O Extreme

Pain:

P1. How often do you experience knee pain?

O Never O Monthly O Weekly O Daily O Always

What amount of knee pain have you experienced the **last week** during the following activities?

P2. Twisting/pivoting on your knee

O None O Mild O Moderate O Severe O Extreme

P3. Straightening knee fully

O None O Mild O Moderate O Severe O Extreme

P4. Bending knee fully

O None O Mild O Moderate O Severe O Extreme

P5. Walking on flat surface

O None O Mild O Moderate O Severe O Extreme

P6. Going up or down stairs

O None O Mild O Moderate O Severe O Extreme

P7. At night while in bed

O None O Mild O Moderate O Severe O Extreme

P8. Sitting or lying

O None O Mild O Moderate O Severe O Extreme

P9. Standing upright

O None O Mild O Moderate O Severe O Extreme

Prospective Cohort
Initial Form (Patient)

Subject ID ☐☐ - ☐☐☐ - ☐

Function, daily living:
The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A1. Descending stairs
O None O Mild O Moderate O Severe O Extreme

A2. Ascending stairs
O None O Mild O Moderate O Severe O Extreme

A3. Rising from sitting
O None O Mild O Moderate O Severe O Extreme

A4. Standing
O None O Mild O Moderate O Severe O Extreme

A5. Bending to floor/pick up an object
O None O Mild O Moderate O Severe O Extreme

A6. Walking on flat surface
O None O Mild O Moderate O Severe O Extreme

A7. Getting in/out of car
O None O Mild O Moderate O Severe O Extreme

A8. Going shopping
O None O Mild O Moderate O Severe O Extreme

A9. Putting on socks/stockings
O None O Mild O Moderate O Severe O Extreme

A10. Rising from bed
O None O Mild O Moderate O Severe O Extreme

A11. Taking off socks/stockings
O None O Mild O Moderate O Severe O Extreme

A12. Lying in bed (turning over, maintaining knee position)
O None O Mild O Moderate O Severe O Extreme

Prospective Cohort
Initial Form (Patient)

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For each of the following activities, please indicate the degree of difficulty you have experienced in the **last week** due to your knee.

A13. Getting in/out of bath
O None O Mild O Moderate O Severe O Extreme

A14. Sitting
O None O Mild O Moderate O Severe O Extreme

A15. Getting on/off toilet
O None O Mild O Moderate O Severe O Extreme

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)
O None O Mild O Moderate O Severe O Extreme

A17. Light domestic duties (cooking, dusting, etc)
O None O Mild O Moderate O Severe O Extreme

Function, sports and recreational activities:
The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your knee.

SP1. Squatting
O None O Mild O Moderate O Severe O Extreme

SP2. Running
O None O Mild O Moderate O Severe O Extreme

SP3. Jumping
O None O Mild O Moderate O Severe O Extreme

SP4. Twisting/pivoting on your injured knee
O None O Mild O Moderate O Severe O Extreme

SP5. Kneeling
O None O Mild O Moderate O Severe O Extreme

Draft

Prospective Cohort
Initial Form (Patient)

Subject ID ☐☐ - ☐☐☐ - ☐

Quality of life:

Q1. How often are you aware of your knee problem?
O Never O Monthly O Weekly O Daily O Constantly

Q2. Have your modified your life style to avoid potentially damaging activities to your knee?
O Not at all O Mildly O Moderately O Severely O Totally

Q3. How much are you troubled with lack of confidence in your knee?
O Not at all O Mildly O Moderately O Severely O Extremely

Q4. In general, how much difficulty do you have with your knee?
O None O Mild O Moderate O Severe O Extreme

MARX SCALE

Please indicate how often you performed each activity **in your healthiest and most active state, in the past year.**

	Less than one time in a month 0	One time in a month 1	One time in a week 2	2 or 3 times in a week 3	4 or more times in a week 4
Running: while playing a sport or jogging	O	O	O	O	O
Cutting: changing directions while running	O	O	O	O	O
Deceleration: coming to a quick stop while running	O	O	O	O	O
Pivoting: turning your body with your foot planted while playing sport; For example: skiing, skating, kicking, throwing, hitting a ball (golf, tennis, squash), etc.	O	O	O	O	O