FUNCTIONAL EVALUATION - KSS

PATIENT ID: Study # Center # Subject #

GENERAL INFORMATION

PATIENT INITIALS:
(If there is no middle initial please use "-")

VISIT DATE: D D / M M M / Y Y Y Y

OPERATIVE SIDE:
(use one form per side)
- ◯ Right
- ◯ Left (Check one)

VISIT :
- ◯ Pre-Op
- ◯ Baseline
- ◯ 3 Month
- ◯ 1 Year
- ◯ 2 Year
- ◯ 5 Year

I. KSS

A. PATIENT CATEGORY: (Check one)
- ◯ Unilateral or Bilateral (opposite knee successfully replaced)
- ◯ Unilateral, Other Knee Symptomatic
- ◯ Multiple Arthritis or Medical Infirmity (specify) _____

II. KSS - PAIN/MOTION SCORE

B. PAIN: (Check one)
- ◯ None
- ◯ Mild or Occasional
- ◯ Mild or Occasional, Stairs Only
- ◯ Mild or Occasional, Walking & Stairs
- ◯ Moderate Occasional
- ◯ Moderate Continual
- ◯ Severe

C. STABILITY: (Amount of Motion)

Anteroposterior (Check one)
- ◯ < 5 mm
- ◯ 5 - 10 mm
- ◯ > 10 mm

Mediolateral (Check one)
- ◯ < 5°
- ◯ 5° - 9°
- ◯ 10° - 14°
- ◯ > 15°

D. RANGE OF MOTION:

	Extension		Flexion
Active:		/	
Passive:		/	

E. FLEXION CONTRACTURE: (Check one)
- ◯ 5° - 10°
- ◯ 11° - 15°
- ◯ 16° - 20°
- ◯ > 20°
- ◯ None

F. EXTENSION LAG: (Check one)
- ◯ <10°
- ◯ 10° - 20°
- ◯ > 20°
- ◯ None

G. ALIGNMENT: (Check one) Degrees
- ◯ Valgus: (please specify degrees) °
- ◯ Varus: (please specify degrees) °

III. KSS - FUNCTION SCORE

H. WALKING AIDS: (Check one)
- ◯ None
- ◯ Cane
- ◯ Two Canes or One Crutch
- ◯ Crutches or Walker
- ◯ Cannot Walk or Wheelchair

I. WALKING: (Check one)
- ◯ Unlimited
- ◯ > 10 Blocks
- ◯ 5 - 10 Blocks
- ◯ < 5 Blocks
- ◯ Housebound
- ◯ Unable

J. STAIRS: (Check one)
- ◯ Normal Up & Down
- ◯ Normal Up; Down with Rail
- ◯ Up & Down with Rail
- ◯ Up with Rail; Unable Down
- ◯ Unable

IV. OTHER

K. TRANSFER ACTIVITY CHAIR TO STANDING: (Check one)
- ◯ Transfer Activity (without assistance)
- ◯ Transfer Activity (with assistance)
- ◯ Cannot Transfer

L. ANTERIOR KNEE PAIN: (Check one)
- ◯ Absent
- ◯ Present If present at 1 yr or later, please explain

_____

M. CLUNK SYNDROME: (Check one)
- ◯ Absent
- ◯ Present

N. CREPITUS: (Check one)
- ◯ Absent
- ◯ Present

O. POST-OP ADVERSE EVENTS SINCE LAST EVALUATION:
- ◯ Yes*
- ◯ No
- ◯ N/A**

*If yes, complete an AE form for each

**Only for use in Pre-Op Evaluation

V. COMMENTS

_____

INVESTIGATOR NAME (PRINT):

INVESTIGATOR SIGNATURE:

DATE: D D / M M M / Y Y Y Y