Nova IH
Knee Pain Qualification Questionnaire

(Please answer ALL of the following questions by circling one answer per question.)

Thank you for completing this questionnaire. Please return to the front desk.

1. Do you experience knee pain? Right / Left / Both
2. Do you experience knee pain at rest? Yes / No
3. Do you have knee osteoarthritis confirmed by imaging (x-ray/MRI)? Yes / No / Unsure
4. Has your knee pain interfered with activities (such as walking, going up/down stairs and/or standing) for at least six months? Yes / No
5. Do you have morning knee stiffness lasting 30 minutes or less? Yes / No
6. Do you experience a grinding sensation with knee movement? Yes / No
7. Have you tried pain and/or anti-inflammatory medications (ie: Tylenol, Aspirin, Advil, or capsaicin cream) for at least three months without gaining long-term relief? Yes / No
8. Have you attempted physical therapy to the affected knee or participated in a personal exercise program without long-term relief? Yes / No
9. Have you attempted to lose weight to help with your knee pain? Yes / No
10. Have you used a knee brace without long-term relief? Yes / No
11. Has your doctor ever drained excess fluid from the affected knee(s)? Yes / No
12. Have you tried steroid/cortisone injection(s) to the knee without long-term relief? Yes / No
13. Has your doctor injected FDA-approved Hyalgan, Orthovisc, Supartz, Synvisc-One or the like greater than six months ago? Yes / No
    - If you did have the previously mentioned injection(s); did you receive significant improvement in pain and functional ability (ie easier to walk and/or stand)? Yes / No
    - If you did have the previously mentioned injection(s); were you able to use fewer pain relieving medications for six months afterwards? Yes / No

PATIENT NAME	DOB

WESTERN ONTARIO AND
MCMASTER OSTEOARTHRITIS INDEX (WOMAC)
Please circle the appropriate rating for each item.

RATE YOUR PAIN WHEN…	NONE	SLIGHT	MODERATE	SEVERE	EXTREME	**OFFICE USE ONLY**
Walking	0	1	2	3	4	
Climbing stairs	0	1	2	3	4	
Sleeping at night	0	1	2	3	4	
Resting	0	1	2	3	4	
Standing	0	1	2	3	4	TOTAL
RATE YOUR STIFFNESS IN THE…	NONE	SLIGHT	MODERATE	SEVERE	EXTREME	**OFFICE USE ONLY**
Morning	0	1	2	3	4	
Evening	0	1	2	3	4	TOTAL
RATE YOUR DIFFICULTY WHEN…	NONE	SLIGHT	MODERATE	SEVERE	EXTREME	**OFFICE USE ONLY**
Descending stairs	0	1	2	3	4	
Ascending stairs	0	1	2	3	4	
Rising from sitting	0	1	2	3	4	
Standing	0	1	2	3	4	
Bending to floor	0	1	2	3	4	
Walking on even floor	0	1	2	3	4	
Getting in/out of car	0	1	2	3	4	
Going shopping	0	1	2	3	4	
Putting on socks	0	1	2	3	4	
Rising from bed	0	1	2	3	4	
Taking off socks	0	1	2	3	4	
Lying in bed	0	1	2	3	4	
Getting in/out of bath	0	1	2	3	4	
Sitting	0	1	2	3	4	
Getting on/off toilet	0	1	2	3	4	WOMAC TOTAL SCORE /96
Doing light domestic duties (cooking, dusting)	0	1	2	3	4	
Doing heavy domestic duties (moving furniture)	0	1	2	3	4	TOTAL
PATIENT SIGNATURE				DATE		
REVIEWED BY				DATE		

Nova IH

WOMAC OSTEOARTHRITIS INDEX QUESTIONNAIRE