

BASELINE QUESTIONNAIRE (ADULT)

THE ROCK GROUP — PROSPECTIVE COHORT STUDY — FORM 2A

SECTION A: STUDY INFORMATION

Subject ID: _____ - _____ - _____ Study Visit: Baseline
Site Number: _____ Date: ____ / ____ / ____
Surgeon ID: _____ Age: _____

SECTION B: CONTACT INFORMATION

First Name: _____ Last Name: _____
Home Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Primary Phone Number: _____ Secondary Phone Number: _____
(____) - _____ - _____ (____) - _____ - _____
Email Address: _____

Sex: Male Female Age: _____ Date of Birth: ____ / ____ / ____

Height (in): _____ Weight (lbs): _____ SSN (optional): _____ - _____ - _____

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

SECTION C: PATIENT HISTORY

C1. Has anyone in your birth family had osteochondritis dissecans (OCD)? Check all that apply.

- No Don't know Mother Father Sister(s)
- Brother(s) Grandmother(s) Grandfather(s) Other _____

C2. Have you been diagnosed with an OCD lesion in any joint before?

- Yes No

C3. If yes, which joint?

- Other Knee Shoulder Elbow Hip Ankle Same Knee

C4. Has anyone in your birth family had focal articular cartilage defects (FCD)?

- No Don't know Mother Father Sister(s)
- Brother(s) Grandmother(s) Grandfather(s) Other _____

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E3. If you have pain, how severe is it?

(0 = No pain and 10 = Worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

E4. During the past 4 weeks, or since your injury, how stiff or swollen was your knee?

Not at all Mildly Moderately Very Extremely

E5. What is the highest level of activity you can perform without significant swelling in your knee?

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

E6. During the past 4 weeks, or since your injury, did your knee lock or catch?

Yes No

E7. What is the highest level of activity you can perform without significant given way in your knee?

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

SECTION F: SPORTS ACTIVITIES

F1. What is the highest level of activity you can participate in on a regular basis?

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

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F2. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Go down stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Kneel on the front of your knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Sit with your knee bent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Rise from a chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Run straight ahead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Jump & land on your involved leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Stop and start quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION G: FUNCTION

G1. 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 usually daily activities which may include sports?

FUNCTION PRIOR TO YOUR KNEE INJURY:

0 = Couldn't perform daily activities 10 = No limitation in daily activities

0 1 2 3 4 5 6 7 8 9 10

CURRENT FUNCTION OF YOUR KNEE:

0 = Cannot perform daily activities 10 = No limitation in daily activities

0 1 2 3 4 5 6 7 8 9 10

SECTION H: KOOS KNEE EVALUATION

This survey asks for your view about your knee. This information will help us keep track 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.

H1. Do you ever have swelling in your knee?

Never Rarely Sometimes Often Always

H2. Do you feel grinding, hear clicking or any other type of noise when your knee moves?

Never Rarely Sometimes Often Always

H3. Does your knee ever catch or hang up when moving?

Never Rarely Sometimes Often Always

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H4. Can you straighten your knee fully?

- Always Often Sometimes Rarely Never

H5. Can you bend your knee fully?

- Always Often Sometimes Rarely Never

SECTION J: 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.

J1. How severe is your knee joint stiffness after first waking in the morning?

- None Mild Moderate Severe Extreme

J2. How severe is your knee stiffness after sitting, lying, or resting later in the day?

- None Mild Moderate Severe Extreme

SECTION K: PHYSICAL FUNCTION

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 what you have experienced during the **last week** due to your knee.

K1. Squatting:

- None Mild Moderate Severe Extreme

K2. Running:

- None Mild Moderate Severe Extreme

K3. Jumping:

- None Mild Moderate Severe Extreme

K4. Twisting/pivoting on your injured knee:

- None Mild Moderate Severe Extreme

K5. Kneeling:

- None Mild Moderate Severe Extreme

SECTION L: QUALITY OF LIFE

L1. How often are you aware of your knee problem?

- Never Monthly Weekly Daily Constantly

L2. Have you modified your life style to avoid potentially damaging activities to your knee?

- Not at all Mildly Moderately Severely Totally

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- L3. How much are you troubled with lack of confidence in your knee?**
 Not at all Mildly Moderately Severely Extremely
- L4. In general, how much difficulty do you have with your knee?**
 None Mild Moderate Severe Extreme

SECTION M: MARX ACTIVITY 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	One time in a month	One time in a week	2 or 3 times in a week	4 or more times in a week
Running: while playing a sport or jogging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cutting: changing directions while running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceleration: coming to a quick stop while running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pivoting: turning your body with your foot planed while playing sport; For example: skiing, skating, kicking, throwing, hitting a ball (golf, tennis, squash), etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION N: SPORTS HISTORY

- N1. At the time your knee pain started or you were diagnosed with OCD/FCD, did you consider yourself an athlete?**
 Yes No
- N2. Did you consider yourself a single-sport or multi-sport athlete?**
 Single-sport Multi-sport
- N3. What was your primary sport?**
 Baseball Basketball Cheerleading Field Hockey Football Gymnastics
 Ice Hockey Lacrosse Rugby Soccer Softball
 Swimming Tennis Track/Field Volleyball Wrestling Other
- N4. In the past year, what was the highest level at which you had participated or were participating in your primary sport?**
 Recreational (causal, pick-up with friends, no organized competition)
 Recreational (competition or events/races)
 Youth League (competition)
 High School (interscholastic competition)
 Semi-Pro / Amateur League
 Professional League

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N5. In the past year, what was the highest frequency at which you had participated or were participating in your PRIMARY sport?

- < 1 time / month
- 1 time / month
- 1 time / week
- 2-3 times / week
- 4+ times / week

N6. In the past year, in what OTHER sports or athletic activities did you participate?
(Select all that apply)

- Baseball
- Basketball
- Cheerleading
- Field Hockey
- Football
- Gymnastics
- Ice
- Hockey
- Lacrosse
- Rugby
- Soccer
- Softball
- Swimming
- Tennis
- Track/Field
- Volleyball
- Wrestling
- Other

N7. In the past year, how often did you play sports (both primary and other sports)?

- < 1 time / month
- 1 time / month
- 1 time / week
- 2-3 times / week
- 4+ times / week

Please answer the following questions based on your sports participation before your knee pain started or you were diagnosed with OCD/FCD

N8. Have you quit other sports to focus on one sport?

- Yes
- No

N9. Do you train more than 8 months out of the year in one sport?

- Yes
- No

N10. Do you consider your primary sport more important than the other sports?

- Yes
- No