

WOMAC Survey Form

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Instructions: In sections A, B, and C, questions will be asked about your hip or knee pain. Please mark each response with an X. If you are unsure about how to answer a question, please give the best answer you can.

A. How much pain do you have (during the last 48 hours)?

	None	Mild	Moderate	Severe	Extreme
1. Walking on a flat surface	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Going up and down stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. At night while in bed, pain disturbs your sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sitting or lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Standing upright	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Think about the stiffness (not pain) you have in your hip/knee during the last 48 hours.

	None	Mild	Moderate	Severe	Extreme
6. How severe is your stiffness after first awakening in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How severe is your stiffness after sitting, lying, or resting in the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Think about the difficulty you had in doing the following daily physical activities due to your hip/knee during the last 48 hours.

	None	Mild	Moderate	Severe	Extreme
8. Descending stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ascending stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Bending to the floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Walking on flat surfaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Getting in and out of a car, or on or off a bus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Going shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Putting your socks or stockings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Rising from the bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Taking off your socks or stockings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Lying in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Getting in or out of the bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Getting on or off the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Performance heavy domestic duties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Performing light domestic duties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name: \_\_\_\_\_ Date: \_\_\_\_\_ (Please circle responses)

**1. Have you had pain recently (within the last 3 months) on the affected knee?**

**Right Knee: Yes / No**

<b>If yes,</b>	<b>location:</b>	Inner	Outer	Front	Back	Allover
	<b>Severity:</b>	None	Mild	Moderate	Severe	Excruciating
	<b>Frequency:</b>	Never	Rarely	Occasionally	Frequently	Always

**Left Knee: Yes / No**

<b>If yes,</b>	<b>location:</b>	Inner	Outer	Front	Back	Allover
	<b>Severity:</b>	None	Mild	Moderate	Severe	Excruciating
	<b>Frequency:</b>	Never	Rarely	Occasionally	Frequently	Always

**2. Do you hear any noises coming from your knee?** No    Right knee    Left knee    Both knees  
**If yes, is it associated with pain?** Yes / No

**3. Do you limp?** Never    Rarely    Occasionally    Frequently    Always  
**If yes, because of your?** right knee / left knee / both knees

**4. Do you have difficulty with:**

<b>a. putting on socks/shoes?</b>	None	Slight	Moderate	Great	Unable
<b>b. personal care (toilet, bathing, etc)</b>	None	Slight	Moderate	Great	Unable
<b>c. household activities (cleaning, etc)</b>	None	Slight	Moderate	Great	Unable
<b>d. getting in and out of a car?</b>	None	Slight	Moderate	Great	Unable
<b>e. kneeling?</b>	None	Slight	Moderate	Great	Unable
<b>f. squatting?</b>	None	Slight	Moderate	Great	Unable
<b>g. sitting on your heels?</b>	None	Slight	Moderate	Great	Unable

**5. How much assistance do you need with going up and down stairs?**  
None    cane/crutch/banister    2 crutches    walker/someone's assistance    Unable

**6. How far can you walk?**  
Unlimited    10+ blocks    4-10 blocks    1-3 blocks    Housebound

**7. Please select your favorite recreational activities and how often you would participate in them:**

<b>a. Walking (&gt;1 mile)</b>	Never	Rarely	Occasionally	Frequently	Always
<b>b. Running</b>	Never	Rarely	Occasionally	Frequently	Always
<b>c. Swimming</b>	Never	Rarely	Occasionally	Frequently	Always
<b>d. Gym Workout</b>	Never	Rarely	Occasionally	Frequently	Always
<b>e. Tennis</b>	Never	Rarely	Occasionally	Frequently	Always
<b>f. Golf</b>	Never	Rarely	Occasionally	Frequently	Always
<b>g. Gardening</b>	Never	Rarely	Occasionally	Frequently	Always
<b>h. Other: _____</b>	Never	Rarely	Occasionally	Frequently	Always

**How often does your affected knee influence or prohibit the performance of these activities?**  
Never    Rarely    Occasionally    Frequently    Always

**8. How often does your affected knee influence your social activities?**  
Never    Rarely    Occasionally    Frequently    Always

**9. How often does your knee pain influence your sense of well being?**  
Never    Rarely    Occasionally    Frequently    Always

**10. Please Rate your degree of satisfaction with your ability to use your knee.**

Unsatisfied 0    1    2    3    4    5    6    7    8    9    10    Fully Satisfied