⑥WOMAC Knee Pain and Disability Questionnaire

Patient's name:	Date:	Study ID:	❑ Before	❑ After	Patient's Signature:

PLEASE READ**:** *Please place a mark on the line that best represents your experience during the* ***last week*** *attributable to your knee problem. Circle the number that best describes your pain where:*
0=no pain, 1 =Mild, 2=Moderate, 3=Severe, 4=Extreme.

How much Pain do you have?		***How much Stiffness you felt in your knee?***	
Walking on a flat surface	0 1 2 3 4	How severe is your stiffness after first awakening in the morning?	0 1 2 3 4
Going up or down stairs	0 1 2 3 4	How severe is your stiffness after sitting or lying or resting later in the day?	0 1 2 3 4
At night while in bed? (that is – pain that disturbs your sleep)	0 1 2 3 4		
Sitting or lying in down	0 1 2 3 4		
Standing upright	0 1 2 3 4		

Think about the difficulty you had in your knee doing the following daily physical activities. By this we mean your ability to move around and take care of yourself			
Going down stairs	0 1 2 3 4	Putting on your shoes or stockings	0 1 2 3 4
Going up the stairs	0 1 2 3 4	Getting out of bed	0 1 2 3 4
Getting up from a sitting position	0 1 2 3 4	Taking off your socks or panty hose or stockings	0 1 2 3 4
Standing	0 1 2 3 4	Lying in bed	0 1 2 3 4
Bending to the floor	0 1 2 3 4	Getting in or out of the bathtub	0 1 2 3 4
Walking on a flat surface	0 1 2 3 4	Sitting	0 1 2 3 4
Getting in or out of a car, or getting on or off a bus	0 1 2 3 4	Getting on or off the toilet	0 1 2 3 4
Going shopping	0 1 2 3 4	Doing heavy household chores	0 1 2 3 4
		Doing light household chores	0 1 2 3 4

Office Use Only

Pain Score: ___ Stiffness Score: ___ Difficulty Score:___ Total Score:____