



MOST PUBLIC DATA RELEASE
ANNOTATED DATA COLLECTION FORMS
15-MONTH FOLLOW-UP DATASET
SEPTEMBER 2021

This document displays the MOST data collection forms, annotated with variable names and data values, used for the instruments and measurements conducted at baseline.

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User Notes

Released variables are displayed in bold blue font.

Example: **MOSTID**

Variables not released are displayed in gray font and lined out (or, where all the variables on a page are not released, the page is crossed out with an "X").

Example: ~~TSHEAR1~~

Calculated variables are displayed in a text box.

Example: **AGECAT**



Telephone Interview First Follow-up Visit



MOST ID #	Acrostic	Date Interview Completed	Site
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="radio"/> SITE 1 <input type="radio"/> SITE 2 SITE
MOSTID	ACROSTIC	Month / Day / Year	

V1_TIDIFF

Knee Symptoms

First, I will be asking you several questions about pain, aching, or stiffness in or around your knees.

Right Knee

The first questions will be specifically about your right knee.

1. During the past 12 months, have you had any pain, aching, or stiffness in your right knee?

V112MR

1 Yes

0 No

8 Don't know/Refused

1a. During the past 12 months, have you had pain, aching, or stiffness in your right knee on most days for at least one month?

Go to Question #3.

V112MSR

1 Yes

0 No

8 Don't know

2. During the past 30 days, have you had any pain, aching, or stiffness in your right knee?

V130DR

1 Yes

0 No

8 Don't know/Refused

Go to Question #3.

2a. During the past 30 days, have you had pain, aching, or stiffness in your right knee on most days?

V130MSR

1 Yes

0 No

8 Don't know

Interviewer Note: Record that participant has right knee pain in Box A (#1a) on page 8, and then proceed to Question #3.

Go to Question #3.

Knee Symptoms

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



Left Knee

Now I'll ask you specifically about your left knee.

3. During the past 12 months, have you had any pain, aching, or stiffness in your left knee?
V112ML Yes No Don't know/Refused

3a. During the past 12 months, have you had pain, aching, or stiffness in your left knee on most days for at least one month?

V112MSL

- Yes No Don't know

Go to Question #5.

4. During the past 30 days, have you had any pain, aching, or stiffness in your left knee?
V130DL Yes No Don't know/Refused

4a. During the past 30 days, have you had pain, aching, or stiffness in your left knee on most days?

V130MSL

- Yes No Don't know

Interviewer Note: Record that participant has left knee pain in Box A (#11a) on page 8, and then proceed to Question #5.

Go to Question #5.

Both Knees

Now I'll ask you about both knees.

5. During the past 30 days, have you limited your activities because of pain, aching, or stiffness in either knee?
V1LA Yes No Don't know/Refused

5a. On how many days did you limit your activities because of pain, aching, or stiffness? days

V1LADAY

5b. During the past 30 days, have you tried to avoid knee pain or reduce the amount of knee pain by avoiding, changing, or cutting back on any of your normal activities?

- Yes No Don't know

V1AVIDT

MOST ID #	Acrostic
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Knee Injury

The next two questions are about knee injuries.

Right Knee

6. Since your last visit to the MOST clinic, have you injured your right knee badly enough to limit your ability to walk for at least two days?

V1LAR 1 Yes 0 No 8 Don't know/Refused

Left Knee

7. Since your last visit to the MOST clinic, have you injured your left knee badly enough to limit your ability to walk for at least two days?

V1LAL 1 Yes 0 No 8 Don't know/Refused



MOST ID #	Acrostic
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Knee Surgery

The next few questions are about knee surgery.

8. Since your last visit to the MOST clinic, did you have any surgery in your right knee?

1 Yes

0 No

8 Don't know/Refused

V1SURGR

Go to Question #10

9. Since your last visit to the MOST clinic, did you have the following types of surgery in your right knee:

a. Arthroscopy (where they put a scope) in your right knee?

1 Yes

0 No

8 Don't know

V1ARTR

b. Meniscectomy (where they repaired or cut away a torn meniscus or cartilage) in your right knee?

1 Yes

0 No

8 Don't know

V1MENR

c. Ligament repair in your right knee?

1 Yes

0 No

8 Don't know

V1LIGR

d. Right total knee replacement, where all or part of the joint was replaced?

Yes

No

Don't know

V12KNRR

Interviewer Note: Please complete the Event Notification Form and mark Right Total Knee Replacement, and then go to Question #9e below.

e. Another kind of surgery in your right knee?

1 Yes

0 No

8 Don't know

V1SOTHR

f. i. **Are any of the answers for Questions #9a-9e above marked "Yes"?**

Yes

No

V12SUMYR

ii. Do you have any metal implants (such as pins, screws, staples, etc.) in your right knee from this surgery?

Yes

No

Don't know

V1MIMPR

Interviewer Note: You will refer to this important information when completing Box A on page 8.

Go to Question #10 on the next page.

Knee Surgery

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



10. Since your last visit to the MOST clinic, did you have any surgery in your left knee?

1 Yes

0 No

8 Don't know/Refused

V1SURGL

Go to Question #12

11. Since your last visit to the MOST clinic, did you have the following types of surgery in your left knee:

<p>a. <u>Arthroscopy</u> (where they put a scope) in your <u>left</u> knee?</p> <p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 8 <input type="radio"/> Don't know</p>	V1ARTL
<p>b. <u>Meniscectomy</u> (where they repaired or cut away a torn meniscus or cartilage) in your <u>left</u> knee?</p> <p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 8 <input type="radio"/> Don't know</p>	V1MENL
<p>c. <u>Ligament repair</u> in your <u>left</u> knee?</p> <p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 8 <input type="radio"/> Don't know</p>	V1LIGL
<p>d. <u>Left total knee replacement</u>, where all or part of the joint was replaced?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>	V12KNRL
<p>Interviewer Note: Please complete the Event Notification Form and mark Left Total Knee Replacement, and then go to Question #11e below.</p>	
<p>e. <u>Another kind of surgery</u> in your <u>left</u> knee?</p> <p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 8 <input type="radio"/> Don't know</p>	V1SOTHL
<p>f. i. Are any of the answers for Questions #11a-11e above marked "Yes"?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	V12SUMYL
<p>ii. Do you have any metal implants (such as pins, screws, staples, etc.) in your <u>left</u> knee from this surgery?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p>	V1MIMPL
<p>Interviewer Note: You will refer to this important information when completing Box A on page 8.</p>	<p>Go to Question #12 on the next page.</p>

Hip Pain

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



The next few questions are about your hip joints.

Right Hip

First I'll ask you about your right hip.

12. During the past 30 days, have you had any pain, aching, or stiffness in or around your right hip? This includes pain in the groin and front and sides of the upper thigh. Do not include pain that was only in your lower back or buttocks.

1 Yes

0 No

8 Don't know/Refused **V1ANYR**

12a. During the past 30 days, have you had pain, aching, or stiffness in your right hip on most days?

1 Yes

0 No

8 Don't know **V1HPN30R**

Left Hip

Now I'll ask you about your left hip.

13. During the past 30 days, have you had any pain, aching, or stiffness in or around your left hip? This includes pain in the groin and front and sides of the upper thigh. Do not include pain that was only in your lower back or buttocks.

1 Yes

0 No

8 Don't know/Refused **V1ANYL**

13a. During the past 30 days, have you had pain, aching, or stiffness in your left hip on most days?

1 Yes

0 No

8 Don't know **V1HPN30L**



MOST ID #	Acrostic													
<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>									<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>					

Hip Surgery/Disability

14. Since your last visit to the MOST clinic, did you have a right total hip replacement, where all or part of the joint was replaced?
- Yes
 No
 Don't know/Refused

Interviewer Note: Please complete the Event Notification Form and mark Right Hip Replacement, and go on to Question #15.

15. Since your last visit to the MOST clinic, did you have a left total hip replacement, where all or part of the joint was replaced?
- Yes
 No
 Don't know/Refused

Interviewer Note: Please complete the Event Notification Form and mark Left Hip Replacement, and go on to Question #16.

Disability Question

16. Are you able to walk by yourself, without the help of another person and without a walker?
- Yes
 No
 Don't know/Refused

V1NOWLK

0

8

Script: "Thank you for your answers so far. Please hold a moment while I review your answers. I will be right with you."

(Interviewer Note: Complete Box A on page 8 before continuing.)

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



Clinic Visit Eligibility

BOX A

I. Right Knee a. Right knee pain on most days during past 30 days? <i>Refer to page 1, Question #2a</i>	<input type="radio"/> Yes →	b. Right knee pain at BASELINE? <i>Refer to Data from Prior Visits Report</i>	<input type="radio"/> Yes → Go to Question #II. <input type="radio"/> No →	d. Was right knee replaced? <i>Refer to page 4, Question #9d and Data from Prior Visits Report</i>	<input type="radio"/> Yes → Go to Question #II. <input type="radio"/> No → Eligible "Case" Go to Question #II.
	<input type="radio"/> No →	c. Right knee randomly selected as a control knee? <i>Refer to Data from Prior Visits Report</i>	<input type="radio"/> Yes → <input type="radio"/> No → Go to Question #II.	e. Was right knee replaced or #9fii marked "Yes"? <i>Refer to page 4, Question #9d & #9f, and Data from Prior Visits Report</i>	<input type="radio"/> Yes → Go to Question #II. <input type="radio"/> No → Eligible "Control" Go to Question #II.
II. Left Knee a. Left knee pain on most days during past 30 days? <i>Refer to page 2, Question #4a</i>	<input type="radio"/> Yes →	b. Left knee pain at BASELINE? <i>Refer to Data from Prior Visits Report</i>	<input type="radio"/> Yes → Go to Question #III. <input type="radio"/> No →	d. Was left knee replaced? <i>Refer to page 5, Question #11d and Data from Prior Visits Report</i>	<input type="radio"/> Yes → Go to Question #III. <input type="radio"/> No → Eligible "Case" Go to Question #III.
	<input type="radio"/> No →	c. Left knee randomly selected as a control knee? <i>Refer to Data from Prior Visits Report</i>	<input type="radio"/> Yes → <input type="radio"/> No → Go to Question #III.	e. Was left knee replaced or #11fii marked "Yes"? <i>Refer to page 5, Question #11d & #11f, and Data from Prior Visits Report</i>	<input type="radio"/> Yes → Go to Question #III. <input type="radio"/> No → Eligible "Control" Go to Question #III.
III. a. Is participant an "Eligible 'Case'" for either knee? See far right column of Questions #I and #II above.	<input type="radio"/> Yes →	Mark "ELIGIBLE FOR 'CASE' CLINIC VISIT" bubble in Box B on page 15, then go to page 9, Question #17.			
	<input type="radio"/> No →	b. Is participant an "Eligible 'Control'" for either knee?	<input type="radio"/> Yes → Mark "ELIGIBLE FOR 'CONTROL' VISIT" in Box B on page 15, then go to page 9, Question #17. <input type="radio"/> No → Mark "NOT ELIGIBLE FOR CLINIC VISIT" in Box B on page 15, then go to page 12, Question #23.		

MRI Eligibility

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



17. Interviewer Note: Refer to Data from Prior Visits Report. Was participant eligible for MRI at baseline?

Yes

No

Go to page 11, Question #21 and mark "No."

The next few questions are about MRI eligibility.

17a. Since your last MRI scan at the MOST clinic, have you had any surgery or anything implanted in your body?

Yes

No

Don't know/Refused

Go to Question #18a.

Go to Question #17c.

17b. What type of surgery or implant was it?

When was the surgery?

<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
Month		Day		Year

Interviewer Note:

If the surgery was within the past 2 months, refer to list of MRI-safe surgeries/procedures that do not require a 2-month wait. If a 2-month wait is required, schedule the clinic visit 2 months after the surgery date.

17c. The next few questions will be about specific implants. Please tell me whether any of the following was implanted in your body during surgery:

i. Electronic implant or device, such as a cochlear implant	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
ii. Magnetically-activated implant or device, such as magnetically-activated dental implant or dentures, or magnetic eye implant	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
iii. Heart pacemaker	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
iv. Implanted heart defibrillator	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
v. Internal electrodes or wires, such as pacemaker wires or bone growth/ bone fusion stimulator wires	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
vi. Neurostimulation system, such as spinal cord stimulator or gastric electrical stimulation system	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
vii. Surgically implanted insulin or drug pump	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
viii. Tissue expander with magnetic port, such as inflatable breast implant with magnetic port	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
ix. Brain aneurysm surgery, brain aneurysm clip(s) or coil(s)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused

17d. Interviewer Note:

Are any of the above items in Question #17c marked "Yes" or "Don't Know/Refused"?

Yes

Not eligible for MRI. Go to page 11, Question #21 and mark "No."

No

MRI Eligibility

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



17e. Please tell me whether any of the following was implanted in your body:	
i. Stent, filter, coil, or clips	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
ii. Shunt (spinal or intraventricular)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
iii. Vascular access port or catheter, such as a central venous catheter or PICC line	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
iv. Surgically implanted hearing device (not a regular hearing aid) or prosthesis in your ear	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
v. Eyelid spring, wire or weights	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
vi. Penile implant or prosthesis (men only)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
vii. Heart valve surgery	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused

- 18a. Since your last visit to the MOST clinic, have you had an injury in which metal fragments entered your eye and you had to seek medical attention? Yes No Don't know/Refused
- 18b. Since your last visit to the MOST clinic, have you had an injury in which metal fragments such as shrapnel, BB, or bullet entered your body? Yes No Don't know/Refused

19. **Interviewer Note:**
Are any of the above items in Question #17e or Questions #18a-18b marked "Yes" or "Don't Know/Refused"?

Yes No

19a. Do you have or would you be willing to ask your doctor for your medical records so that we could determine whether it would be safe for you to have an MRI scan?

Yes No

Interviewer Note: Ask participant to bring medical documentation with them to the clinic visit.

Not eligible for MRI. Go to page 11, Question #21 and mark "No."



MOST ID #	Acrostic
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MRI Eligibility

20. Interviewer Note:
Is there any other reason why this participant would not be eligible for an MRI?

Yes No

What is the reason?

Not eligible for MRI. Go to Question #21 and mark "No."

21. Interviewer Note:
Is the participant eligible for an MRI scan? (Refer to Questions #17, #19a-19b, and #20.)

Yes No

Go to Question #22.

21a. Is study participant an "Eligible Case" (Refer to page 8, Question #11a)?

Yes No

"ELIGIBLE FOR 'CASE' CLINIC VISIT" should be marked in Box B on page 15. Go to page 12, Question #23.

Change status to "NOT ELIGIBLE FOR CLINIC VISIT" in Box B on page 15, and go to page 12, Question #23.

22. Are you planning to have surgery in the next month?

Yes No Don't know/Refused

22a. What is the date of your scheduled surgery?

/ /
 Month Day Year

What type of surgery will you have?

Interviewer Note: Refer to list of surgeries/procedures that do not require a 2-month wait. If surgery is on that list, mark "No" for this question. If a 2-month wait is required, go to page 12, Question #23. Do not scan today's Telephone Interview forms. Re-contact 2 months after surgery to reassess eligibility.

Fracture History

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



23. Since your last visit to the MOST clinic, did a doctor tell you that you broke or fractured a bone?

1 Yes

0 No

8 Don't know/Refused

V1BONE

Go to page 13, Question #24.

23a. Were you told that you broke or fractured your hip?

1 Yes

0 No

8 Don't know/Refused

V1FXHIP

23b. Were you told that you had a fracture of the spine or fracture of the vertebrae?

1 Yes

0 No

8 Don't know/Refused

V1SPINE

V1_FXHIPSP

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



Contact Information

- 24.** We would like to update all of your contact information this year. The address that we currently have listed for you is:

(Interviewer Note: Please review the participant's contact information and confirm that the address you have for the participant is correct.)

Is the address that we currently have correct?

Yes

No

Interviewer Note: Please record the street address, city, state and zip code for the participant for your local records.

- 25.** The telephone number(s) that we currently have for you is (are):

(Interviewer Note: Please review the participant's contact information and confirm that the telephone number(s) you have for the participant are correct.)

Are the telephone number(s) that we currently have correct?

Yes

No

Interviewer Note: Please record the telephone number(s) for the participant for your local records.

- 26.** Do you expect to move or have a different address in the next 6 months?

Yes

No

Don't know/Refused

Interviewer Note: Please record the street address, city, state and zip code for the participant for your local records.

Contact Information

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



27. Interviewer Note: Has the participant identified their next of kin?

Yes
↓

No →

27a. Interviewer Note: Please review the participant's next of kin contact information from baseline.

You previously told us the name and address of your next of kin. Please tell me if the information that I have is still correct. Is the name and address of your next of kin correct?

Yes
↓

No

Don't know

Refused
↓

28. Please tell me the name, address, and telephone number of your next of kin. How is this person related to you?

Interviewer Note: Please record the name, street address, city, state, zip code, telephone number, and how the person is related to the participant.

29. Interviewer Note: Has the participant identified their two contacts?

Yes
↓

No →

29a. Interviewer Note: Please review the participant's information for their two contacts.

You previously told us the names and addresses of your two contacts. Please tell me if the information that I have is still correct. Are the names and addresses of your two contacts correct?

Yes
↓

No

Don't know

Refused
↓

30. Please tell me the name, address, and telephone number of your first contact. How is this person related to you?

Please tell me the name, address, and telephone number of your second contact. How is this person related to you?

Interviewer Note: For both contacts, please record the name, street address, city, state, zip code, telephone number, and how the person is related to the participant.



MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Clinic Visit Eligibility

BOX B

ELIGIBLE FOR "CASE" CLINIC VISIT

"Thank you for your time and for answering our questions. We'd like to schedule you for a clinic visit. You will be scheduled for knee MRIs, knee X-rays, and a knee and hip exam. Your visit will last for about 2 to 3 hours. Before I schedule your appointment, do you have any questions?"

- Appointment scheduled **Date:** _____ **Time:** _____
- Call back for appointment **Date:** _____ **Time:** _____

"Please bring in all your prescription and non-prescription medications, vitamins and supplements that you have taken in the past 30 days."

ELIGIBLE FOR "CONTROL" VISIT

"Thank you for your time and for answering our questions. We'd like to schedule you for a 1 to 2 hour clinic visit including a knee MRI. Before I schedule your appointment, do you have any questions?"

- Appointment scheduled **Date:** _____ **Time:** _____
- Call back for appointment **Date:** _____ **Time:** _____

"Please bring in all your prescription and non-prescription medications, vitamins and supplements that you have taken in the past 30 days."

NOT ELIGIBLE FOR CLINIC VISIT

"Thank you for your time and for answering our questions. That's all the information that I need from you at this time. We will be contacting you in about 12 months to schedule a MOST clinic visit. Do you have any questions?"

NOT INTERESTED

"Your participation in this important study is appreciated. Can you tell me why you aren't interested in coming to the MOST clinic at this time? _____"

Thank you for your time and for answering our questions. We will be contacting you again in about 12 months. Do you have any questions?"

Self-Administered Questionnaire First Follow-up Visit



MOST ID#	Acrostic	Date Form Completed	Staff ID#
<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <small>Month Day Year</small>	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>

Joint Pain, Aching, and Stiffness

1. On most days, do you have pain, aching, or stiffness in any joints?
- Yes No Don't know **V1JPAIN**

Go to Page #2, Question #2.

Please fill in the bubbles in the pictures below to show which joints have had **pain, aching, or stiffness** on most days in the past 30 days. *(Please mark all that apply.)*

Right
Left

Shoulders
V1SHDRR **V1SHDRL**

Elbows
V1ELBR **V1ELBL**

Hips
V1HIPR **V1HIPL**

Wrists
V1WRSTR **V1WRSTL**

Hands
V1HANDR **V1HANDL**

Knees
V1KNR **V1KNL**

Ankles
V1ANKLR **V1ANKLL**

Feet
V1FOOTR **V1FOOTL**

V1NECK

Neck

V1_WSPA

V1_WSPB

1=YES



Scoring for WOMAC[®] Likert 3.1

MOST uses a modified version of the WOMAC[®] Likert 3.1 instrument. WOMAC[®] is a registered trademark (CDN No. TMA 545,986), Copyright 1996 Nicholas Bellamy, All Rights Reserved. This copyrighted instrument may not be displayed. Therefore the top of page 2, bottom of page 4, and complete pages 3, 5, 6, 8, and 9 of the MOST First Follow-up Self-Administered Questionnaire – Clinic are not being displayed.

Please go to: <http://www.womac.org> for more information about the WOMAC[®] Likert 3.1.

WOMAC[®] subscales

There are three WOMAC[®] subscales: pain, stiffness, and disability. The time period covered by the subscales is the “past 30 days.” Subscale scores are the sum of individual item scores for all items in the subscale.

Knee pain

The individual items in the pain subscale are:

<u>Activity</u>	<u>Variable (right knee)</u>	<u>Variable (left knee)</u>
Walking	V1Q1KR	V1Q1KL
Up stairs	V1UPR	V1UPL
Down stairs	V1DOWNR	V1DOWNL
Stairs (calculated)	V1Q2KR	V1Q2KL
In bed	V1Q3KR	V1Q3KL
Sit or lie down	V1Q4KR	V1Q4KL
Standing	V1Q5KR	V1Q5KL

Each knee pain item is scored on a 5-point scale:

- 0 = None
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Extreme
- 5 = Don't do*
- .M = Missing

*The following variables have the 5 (don't do) scoring option: V1UPR, V1UPL, V1DOWNR, and V1DOWNL. “Don't do” is set to missing.

The pain subscale scores are calculated for the right and left knee separately. The pain subscale possible score range is 0-20.

<u>Score</u>	<u>Variable (right knee)</u>	<u>Variable (left knee)</u>
Pain subscale scores	V1WOPNKR	V1WOPNKL

(Note: the top of page 2, bottom of page 4, and complete pages 3, 5, 6, 8, and 9 of the MOST First Follow-up Self-Administered Questionnaire – Clinic are not being displayed)



Knee stiffness

The individual items in the stiffness subscale are:

<u>Activity</u>	<u>Variable (right knee)</u>	<u>Variable (left knee)</u>
In morning	V1Q6KR	V1Q6KL
Later in day	V1Q7KR	V1Q7KL

Each knee stiffness item is scored with the same scale used for knee pain, except the “5” scoring option (see previous page) is not available.

The stiffness subscale scores are calculated for the right and left knee separately. The stiffness subscale possible score range is 0-8.

<u>Score</u>	<u>Variable (right knee)</u>	<u>Variable (left knee)</u>
Stiffness subscale scores	V1WOSTKR	V1WOSTKL

Disability

The individual items in the disability subscale are:

<u>Activity</u>	<u>Variable (either knee)</u>
Down stairs	V1Q8K
Up stairs	V1Q9K
Stand from sitting	V1Q10K
Standing	V1Q11K
Bending	V1Q12K
Walking	V1Q13K
In car/out of car	V1Q14K
Shopping	V1Q15K
Socks on	V1Q16K
Get out of bed	V1Q17K
Socks off	V1Q18K
Lying down	V1Q19K
Bathing	V1Q20K
Sitting	V1Q21K
On/off toilet	V1Q22K
Heavy chores	V1Q23K
Light chores	V1Q24K

Each disability item is scored for difficulty with the same scale used for pain and stiffness (see previous page).

*The following variables have the 5 (don't do) scoring option: V1Q8K, V1Q9K, V1Q12K, V1Q15K, V1Q23K, and V1Q24K. “Don't do” is set to missing.

The disability subscale possible score range is 0-68.

<u>Score</u>	<u>Variable (either knee)</u>
Disability subscale scores	V1WOPASK

(Note: the top of page 2, bottom of page 4, and complete pages 3, 5, 6, 8, and 9 of the MOST First Follow-up Self-Administered Questionnaire – Clinic are not being displayed)

Most First Follow up
Self-Administered Questionnaire – Clinic



Total scores

The total scores are the sum of the pain, stiffness and disability subscale scores for the right and left knee, respectively. The possible score range is 0-96.

<u>Score</u>	<u>Variable (right knee)</u>	<u>Variable (left knee)</u>
Total scores	V1WOTOTR	V1WOTOTL

Hip pain

The individual items in the pain subscale are:

<u>Activity</u>	<u>Variable (right knee)</u>	<u>Variable (left knee)</u>
Walking	V1Q1HR	V1Q1HL
Up/down stairs	V1Q2HR	V1Q2HL
In bed	V1Q3HR	V1Q3HL
Sit or lie down	V1Q4HR	V1Q4HL
Standing	V1Q5HR	V1Q5HL
Socks on	V1Q6HR	V1Q6HL
In chair/out of chair	V1Q7HR	V1Q7HL
In car/out of car	V1Q8HR	V1Q8HL

Each knee pain item is scored on a 5-point scale:

- 0 = None
- 1 = Mild
- 2 = Moderate
- 3 = Severe
- 4 = Extreme
- 5 = Don't do*
- .M = Missing

*The following variables have the 5 (don't do) scoring option: V1Q2HR and V1Q2HL. "Don't do" is set to missing.

The pain subscale scores are calculated for the right and left hip separately. V1WOPNHR and V1WOPNHL are standard calculations and V1WOPHRM and V1WOPHLM include three physical function questions. The possible score range is 0-20 for pain and 0-32 for pain/disability.

<u>Score</u>	<u>Variable (right hip)</u>	<u>Variable (left hip)</u>
Pain subscale scores	V1WOPNHR	V1WOPNHL
Pain/disability subscale scores	V1WOPHRM	V1WOPHLM

(Note: the top of page 2, bottom of page 4, and complete pages 3, 5, 6, 8, and 9 of the MOST First Follow-up Self-Administered Questionnaire – Clinic are not being displayed)

Most First Follow up
Self-Administered Questionnaire – Clinic



Score calculations

An individual response of:

5 = Don't do

.M = Missing

For any item is treated as missing data.

Modified WOMAC Osteoarthritis Index Likert Version 3.1 (1996). Subscales are for knee pain and stiffness, hip pain, physical function, and degree of difficulty (when physically active). In addition to asking about degree of physical difficulty going up stairs and going down stairs, in MOST we also ask separate knee pain questions regarding going up stairs and going down stairs. The stair climbing calculation was based on the highest response value of the two questions. If there is one missing answer and one non-missing answer for the stair climbing questions, the non-missing answer is used. Subsets of the questions have a "don't do" response option. If the participant chose the "don't do" response, the score for that question was set to missing when computing WOMAC scores. Participant responses are all based on the past 30 days.

In MOST, WOMAC pain questions are also asked about the hips (five questions). In addition, three of the physical function questions of interest (pain experienced while putting on socks, getting in or out of a chair, and getting in or out of a car) are also asked about the hips. The modified hip pain subscale was calculated based on these 8 questions.

The WOMAC knee calculated variable and subscales were calculated based on code from Jingbo Niu at Boston University (Framingham Study).

The method used to handle missing values (ie., participant fails to/refuses to complete all questions) is consistent with the suggestion from the WOMAC User's Guide (Nicholas Bellamy) for how missings should be treated: "If \geq two pain, both stiffness, or \geq four physical function items are omitted, the patient's response is regarded as invalid and the deficient subscale(s) should not be used in analysis. Where one pain, one stiffness, or 1-3 physical function items are missing, we suggest substituting the average value for the subscale in lieu of the missing item value(s). This method is similar to that employed for other indices (e.g., SF-36)."

(Note: the top of page 2, bottom of page 4, and complete pages 3, 5, 6, 8, and 9 of the MOST First Follow-up Self-Administered Questionnaire – Clinic are not being displayed)

Most First Follow up
Self-Administered Questionnaire – Clinic

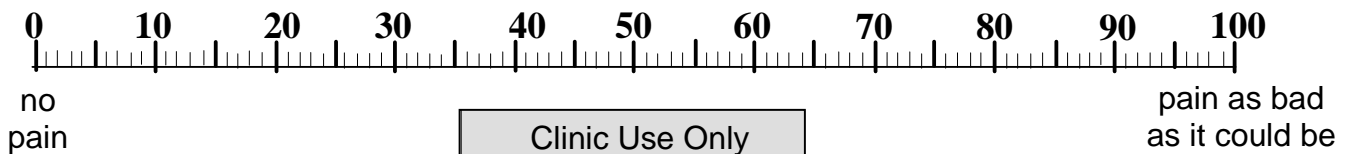
Knee Symptoms

MOST ID #						Acrostic		



Note: WOMAC© was removed from this page. See "Scoring for WOMAC©" documentation on page [17].

3. How bad has the pain been in your right knee, on average, in the past 30 days? Please mark an "X" on the line below: ("0" means "no pain" and "100" means "pain as bad as it could be")



V1VASKR

Clinic Use Only		

Knee Symptoms

MOST ID #	Acrostic
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>



7. How bad has the pain been in your left knee, on average, in the past 30 days? Please mark an "X" on the line below. ("0" means "no pain" and "100" means "pain as bad as it could be")

0	10	20	30	40	50	60	70	80	90	100						
no pain										pain as bad as it could be						
				<table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th colspan="3" style="text-align: center;">Clinic Use Only</th> </tr> </thead> <tbody> <tr> <td style="width: 20px; height: 20px;"><input type="text"/></td> <td style="width: 20px; height: 20px;"><input type="text"/></td> <td style="width: 20px; height: 20px;"><input type="text"/></td> </tr> </tbody> </table>			Clinic Use Only			<input type="text"/>	<input type="text"/>	<input type="text"/>				
Clinic Use Only																
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				V1VASKL												

Note: WOMAC© was removed from this page. See "Scoring for WOMAC©" documentation on page [17].

Physical Difficulty

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



The next questions are about the amount of difficulty you may have when you are **more physically active**. For each of the following activities, please indicate the **degree of difficulty** you have experienced **during the past 30 days** due to pain and discomfort **in either knee**.

11. QUESTION: What degree of difficulty do you have due to pain, discomfort or arthritis in your knee(s)?		
a. Squatting <input type="radio"/> 0 none <input type="radio"/> 1 mild <input type="radio"/> 2 moderate <input type="radio"/> 3 severe <input type="radio"/> 4 extreme <input type="radio"/> 5 don't do		V1SP1K
b. Running/jogging <input type="radio"/> 0 none <input type="radio"/> 1 mild <input type="radio"/> 2 moderate <input type="radio"/> 3 severe <input type="radio"/> 4 extreme <input type="radio"/> 5 don't do		V1SP2K
c. Jumping <input type="radio"/> 0 none <input type="radio"/> 1 mild <input type="radio"/> 2 moderate <input type="radio"/> 3 severe <input type="radio"/> 4 extreme <input type="radio"/> 5 don't do		V1SP3K
d. Twisting/pivoting on your knees <input type="radio"/> 0 none <input type="radio"/> 1 mild <input type="radio"/> 2 moderate <input type="radio"/> 3 severe <input type="radio"/> 4 extreme <input type="radio"/> 5 don't do		V1SP4K
e. Kneeling <input type="radio"/> 0 none <input type="radio"/> 1 mild <input type="radio"/> 2 moderate <input type="radio"/> 3 severe <input type="radio"/> 4 extreme <input type="radio"/> 5 don't do		V1SP5K

V1KOOSSP



MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Everyday Things

This questionnaire asks about everyday things that you do at this time in your life. **(For example, you might feel limited because of your health, or because it takes a lot of mental and physical energy. Please keep in mind that you can also feel limited by factors outside of yourself. Your environment could restrict you from doing things; for instance, transportation issues, accessibility, and social or economic circumstances could limit you from doing things you would like to do. Think of all these factors when you answer this section.)**

Answer every question by selecting the answer as indicated. If you are unsure about how to answer, please give the best ONE answer you can.

To what extent do you feel limited in...?	Not at all	A little	Somewhat	A lot	Completely	
14. Visiting friends and family in their homes	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI1
15. Providing care or assistance to others. This may include providing personal care, transportation, and running errands for family members or friends.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI2
16. Taking care of the inside of your home. This includes managing and taking responsibility for homemaking, laundry, housecleaning and minor household repairs.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI3
17. Working at a volunteer job outside your home.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI4
18. Taking part in active recreation. This may include bowling, golf, tennis, hiking, jogging, or swimming.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI5
19. Traveling out of town for at least an overnight stay.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI6
20. Taking part in a regular fitness program. This may include walking for exercise, stationary biking, weight lifting, or exercise classes.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI7
21. Going out with others to public places such as restaurants or movies.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI8

Everyday Things

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



To what extent do you feel limited in...?	Not at all	A little	Somewhat	A lot	Completely	
22. Taking care of your own personal care needs. This includes bathing, dressing, and toileting.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI9
23. Taking part in organized social activities. This may include clubs, card playing, senior center events, community or religious groups.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI10
24. Taking care of local errands. This may include managing and taking responsibility for shopping for food and personal items, and going to the bank, library, or dry cleaner.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI11
25. Preparing meals for yourself. This includes planning, cooking, serving, and cleaning up.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	V1FDI12

V1LLDIIR

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



Health Survey

This survey asks for your views about your health.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the ONE best answer you can.

26. In general, would you say your health is:

- V1SF1**
- 1 Excellent
 - 2 Very good
 - 3 Good
 - 4 Fair
 - 5 Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
27. <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf V1SF2	1 <input type="radio"/>	2 <input type="radio"/>	0 <input type="radio"/>
28. Climbing <u>several</u> flights of stairs V1SF3	1 <input type="radio"/>	2 <input type="radio"/>	0 <input type="radio"/>

During the past 30 days, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

29. <u>Accomplished less than you would like</u> V1SF4	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
30. Were limited in the <u>kind</u> of work or other activities V1SF5	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know

During the past 30 days, have you had any of the following problems with your work or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)?

31. <u>Accomplished less</u> than you would like V1SF6	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
32. Didn't do work or other activities as <u>carefully</u> as usual V1SF7	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know

Health Survey

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



33. During the past 30 days, how much did pain interfere with your normal work (including both work outside the home and housework)? *(Please choose ONE answer.)*

V1SF8

- 0 Not at all
- 1 A little bit
- 2 Moderately
- 3 Quite a bit
- 4 Extremely

These questions are about how you feel and how things have been with you during the past 30 days. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 30 days . . .

	All of the time	Most of the time	A good bit of the time	Some of the time	A little bit of the time	None of the time
34. Have you felt calm and peaceful? V1SF9	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	0 <input type="radio"/>
35. Did you have a lot of energy? V1SF10	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	0 <input type="radio"/>
36. Have you felt downhearted and blue? V1SF11	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	0 <input type="radio"/>

37. During the past 30 days, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)? *(Please choose ONE answer.)*

- V1SF12
- | | | | | |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| 4 <input type="radio"/> | 3 <input type="radio"/> | 2 <input type="radio"/> | 1 <input type="radio"/> | 0 <input type="radio"/> |

V1SF12MM

V1SF12MP

Clinic Visit With X-ray Procedure Checklist



MOST ID #	Acrostic	Date Form Completed	Staff ID#
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small>	<input type="text"/> <input type="text"/> <input type="text"/>

V1_DATEDIFF

Measurement	Page #	Completed	Partially completed	Participant refused	Not done/ Not applicable
1. Were the knee symptoms questions administered?	2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Medications	4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Weight	6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. OrthOne 1.0 T Knee MRI	7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Knee X-ray	12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Knee and Hip Examinations	13	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Physician Confirmatory Knee and Hip Examinations	10a	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Was the Self-Administered Questionnaire completed and checked?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Clinic Visit Without X-ray Procedure Checklist



MOST ID #	Acrostic	Date Form Completed			Staff ID#																												
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		Month	/	Day	/	Year																											

V1_DATEDIFF

Measurement	Page #	Completed	Partially completed	Participant refused	Not done/ Not applicable
1. Were the knee symptoms questions administered?	2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Medications	4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Weight	6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. OrthOne 1.0 T Knee MRI	7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Was the Self-Administered Questionnaire completed and checked?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

MOST ID #	Acrostic	Staff ID#
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="radio"/> Control <input type="radio"/> Case V1CASE		



Knee Symptoms

I would like to ask you several questions about pain, aching, or stiffness in or around your knees.

Right Knee

First I'll ask you about your right knee.

1. During the past 12 months, have you had any pain, aching, or stiffness in your right knee?
- V1KPN12R** Yes No Don't know/Refused

1a. During the past 12 months, have you had pain, aching, or stiffness in your right knee on most days for at least one month?

Yes No Don't know

Go to Question #3.

V1MNTHR

2. During the past 30 days, have you had any pain, aching, or stiffness in your right knee?
- V1PN30R** Yes No Don't know/Refused

2a. During the past 30 days, have you had pain, aching, or stiffness in your right knee on most days?

V1KPN30R Yes No Don't know

V1R_FKP

V1R_SX

MOST ID #						Acrostic			
○ Control						○ Case			



Knee Symptoms

Left Knee

Now I'll ask you about your left knee.

3. During the past 12 months, have you had any pain, aching, or stiffness in your left knee?

V1KPN12L

1
○ Yes

0
○ No

8
○ Don't know/Refused

3a. During the past 12 months, have you had pain, aching, or stiffness in your left knee on most days for at least one month?

1
○ Yes

0
○ No

8
○ Don't know

V1MNTHL

Go to page 4, Question #1.

4. During the past 30 days, have you had any pain, aching, or stiffness in your left knee?

V1PN30L

1
○ Yes

0
○ No

8
○ Don't know/Refused

Go to page 4, Question #1.

4a. During the past 30 days, have you had pain, aching, or stiffness in your left knee on most days?

V1KPN30L

1
○ Yes

0
○ No

8
○ Don't know

V1L_FKP

V1L_SX

V1_FKPSX

MOST ID #						Acrostic			
○ Control			○ Case						



Medication Use Interview

1. Not counting multi-vitamins, are you currently taking any of the following specific vitamins every day or almost every day?

a. Vitamin E

V1VITE **1** Yes **0** No **8** Don't know/Refused

↓

What is the total dose per day you take most of the time?

V1VITED

1 Less than 100 IU
2 100 to 250 IU
3 300 to 500 IU
4 600 IU or more
8 Don't know

b. Vitamin C

V1VITC **1** Yes **0** No **8** Don't know/Refused

↓

What is the total dose per day you take most of the time?

V1VITCD

1 Less than 400 mg
2 400 to 700 mg
3 750 to 1,250 mg
4 1,300 mg or more
8 Don't know

MOST ID #	Acrostic
<input type="text"/>	<input type="text"/>



Medication Inventory Form

2. Did the participant bring in or identify ALL targeted prescription and non-prescription medications, supplements, and vitamins that they took during the last 30 days? *(Refer to Medication Operations Manual for description of targeted medications.)*

V1MEDS

All
 Some
 None
 Took None

Total number recorded: **V1NUM** medications
 Arrange for telephone call to complete MIF

PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS

Record the name of the prescription or non-prescription medicine, frequency of use, and formulation code. Mark whether or not it is a prescription drug.

V1MNUM Med # **V1FRMCODE** Formulation code:

V1NAME

Name:

V1DUR Duration of use: < 1 month
 1 month to < 1 year
 1 to < 3 years
 3 to < 5 years
 ≥ 5 years
 Don't know

V1RX Prescription? Yes No
Frequency? As Needed Reg **V1FREQ**

V1SAME	V1CHONDR	V1FLUOR	V1RALOX
V1ALENDR	V1CSTERD	V1GLCSMN	V1RISEDR
V1ANALGS	V1COXII	V1HYALUR	V1SALICY
V1BISPHOS	V1MSM	V1NARCAN	V1TPTD
V1CALCIT	V1DOXY	V1NSAID	V1VITMND
V1CALCUM	V1ESTROG	V1PROGST	V1OSTEOP

Formulation Codes:

1=oral tablet or capsule; 2=oral liquid; 3=topical liquid, lotion, or ointment; 4=ophthalmic; 5=rectal or vaginal; 6=inhaled; 7=injected; 8=transdermal patch; 9=powder; 10=nasal

MOST ID #	Acrostic	Staff ID#
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
<input type="radio"/> Control <input type="radio"/> Case		V1STFID



Weight

1. Weight is measured without shoes or heavy jewelry and in the standard gown or lightweight clothing.

V1WGHT . kg

V1WT

V1BMI

OrthOne 1.0 T Knee MRI

MOST ID #	Acrostic	Date Form Completed	Staff ID#
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="radio"/> Control <input type="radio"/> Case		Month Day Year	



First knee MRI Repeat knee MRI

Confirm that this is the correct participant: Ask their name, confirm in chart that the name matches the MOST ID# and Acrostic at the top of this form.

1. Was participant eligible for MRI at time of Follow-up Telephone Interview?

(Examiner Note: Refer to Data from Prior Visits Report)

Yes

No

Not eligible for MRI. Go to page 10, Question #11.

2. Does participant weigh > 350 lbs (>159.1 kg)?

(Examiner Note: Do not re-weigh participant. Check weight measurement on page 6 in the Clinic Visit Workbook.)

Yes

No

Not eligible for MRI. Go to page 10, Question #11.

3. Have you had any surgery in the past 2 months?

Yes

No

Don't know

3a. What type of surgery was it?

When was the surgery? *(Examiner Note: If participant unsure, please probe.)*

/ /

Month Day Year

Go to page 8, Question #4.

3b. Does the surgery require a 2-month wait before an MRI can be performed?

(Examiner Note: Refer to the list of MRI-safe surgeries/procedures that do not require a 2-month wait. If the surgery or procedure does not require a 2-month wait, mark "No".)

Yes

No

Not eligible for MRI at this time. Go to page 12, Question #11 (next exam). Schedule MRI for 2 months after surgery date. Complete and scan pages 8, 9, 10, and 11 when participant returns for MRI.

Go to page 8, Question #4.

OrthOne 1.0 T Knee MRI

MOST ID #	Acrostic
<input type="text"/>	<input type="text"/>
<input type="radio"/> Control	<input type="radio"/> Case



First knee MRI Repeat knee MRI

4. The next few questions will be about specific implants. Please tell me whether you currently have any of the following implanted in your body:

i. Electronic implant or device, such as a cochlear implant	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
ii. Magnetically-activated implant or device, such as magnetically-activated dental implant or dentures, or magnetic eye implant	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
iii. Heart pacemaker	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
iv. Implanted heart defibrillator	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
v. Internal electrodes or wires, such as pacemaker wires or bone growth/ bone fusion stimulator wires	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
vi. Neurostimulation system, such as spinal cord stimulator or gastric electrical stimulation system	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
vii. Surgically implanted insulin or drug pump	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
viii. Tissue expander with magnetic port, such as inflatable breast implant with magnetic port	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
ix. Brain aneurysm surgery, brain aneurysm clip(s) or coil(s)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused

4a. Examiner Note:

Are any of the above items in Question #4 marked "Yes" or "Don't Know/Refused"?

Yes

Not eligible for MRI. Go to page 10, Question #11 and mark "No."

No

5. Please tell me whether any of the following is currently implanted in your body:

i. Stent, filter, coil, or clips	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
ii. Shunt (spinal or intraventricular)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
iii. Vascular access port or catheter, such as a central venous catheter or PICC line	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
iv. Surgically implanted hearing device (not a regular hearing aid) or prosthesis in your ear	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
v. Eyelid spring, wire or weights	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
vi. Penile implant or prosthesis (men only)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
vii. Heart valve surgery	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused

5a. Since your last visit to the MOST clinic, have you had an injury in which metal fragments entered your eye and you had to seek medical attention? Yes No Don't know/Refused

5b. Since your last visit to the MOST clinic, have you had an injury in which metal fragments such as shrapnel, BB, or bullet entered your body? Yes No Don't know/Refused

MOST ID #	Acrostic
<input type="text"/>	<input type="text"/>
<input type="radio"/> Control	<input type="radio"/> Case



OrthOne 1.0 T Knee MRI

First knee MRI Repeat knee MRI

6. Are any of the items in Question #5 or Questions #5a - 5b on the previous page marked "Yes" or "Don't Know/Refused"? Yes No

6a. Does the participant have medical documentation that shows that it is safe to have an MRI scan?
(**Examiner Note: If documentation is not already in the chart, ask participant if they brought medical documentation showing that it is safe to have an MRI.**)

Yes No

Place documentation in participant's chart and have authorized staff person sign here: _____

Not eligible for MRI. Go to Question #9.

7. Is there any other reason why this participant would not be eligible for an MRI?

Yes No

What is the reason?

Not eligible for MRI.
Go to Question #9.

8. Has the participant had a knee replacement (where all or part of their joint was replaced), or knee surgery with metal implants in either knee? (**Examiner Note: Refer to Data from Prior Visits Report.**)

Yes No

Which knee was replaced or has metal implants?
 Right Left
 Do not scan right knee. Do not scan left knee.

9. Is the participant eligible for an OrthOne 1.0 T knee MRI scan?

Yes No

Tech. signature: _____

Go to page 10, Question #11.

10. Which knee(s) is being scanned?

(**Examiner Note: To determine which knee(s) to scan:**

a. If control, refer to Question #8 above and to Data from Prior Visits Report.

b. If case, scan both knees unless contraindicated - refer to Question #8 above.)

Right knee Left knee Both knees

Complete Question #11a and #12a

Complete Question #11b and #12b

Complete Question #11a and #11b and #12a and #12b

OrthOne 1.0 T Knee MRI

First knee MRI Repeat knee MRI

MOST ID #	Acrostic	Date of Scan		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="radio"/> Control <input type="radio"/> Case		Month	Day	Year



11. a. Was an MRI obtained of the right knee?

V1ONIR 1 Yes

0 No →

Why wasn't a right knee MRI obtained? (**Mark only one**)

1 Participant not eligible
 2 Participant had right total knee replacement
 3 Participant's leg did not fit in MRI scanner V1NOR
 4 Participant refused
 5 Participant scheduled for a later date
 6 Other (**Please specify:** _____)
 _____)

b. Was an MRI obtained of the left knee?

V1ONIL 1 Yes

0 No →

Why wasn't a left knee MRI obtained? (**Mark only one**)

1 Participant not eligible
 2 Participant had left total knee replacement
 3 Participant's leg did not fit in MRI scanner V1NOL
 4 Participant refused
 5 Participant scheduled for a later date
 6 Other (**Please specify:** _____)
 _____)

OrthOne 1.0 T Knee MRI

First knee MRI Repeat knee MRI

MOST ID #	Acrostic	Date of Scan
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="radio"/> Control <input type="radio"/> Case		Month Day Year



MRI Technologist ID#

12. Was an OrthOne 1.0 T knee MRI reviewed and obtained for each of the following sequences?

a. Right knee scan

i. Was the baseline right knee scan viewed?
 Yes No —————> Reason: _____

ii. Axial
 Yes No —————> Reason: _____

iii. Sagittal
 Yes No —————> Reason: _____

iv. Coronal STIR
 Yes No —————> Reason: _____

v. 3 Point Dixon
 Yes No —————> Reason: _____

b. Left knee scan

i. Was the baseline left knee scan viewed?
 Yes No —————> Reason: _____

ii. Axial
 Yes No —————> Reason: _____

iii. Sagittal
 Yes No —————> Reason: _____

iv. Coronal STIR
 Yes No —————> Reason: _____

v. 3 Point Dixon
 Yes No —————> Reason: _____

MOST ID #	Acrostic	Date Form Completed			Staff ID#
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Month	Day	Year	

Knee X-ray

First knee x-ray
 Repeat knee x-ray
V1XYVIS

1. Confirm that this is the correct participant: Ask their name, confirm in chart that the name matches the MOST ID# and Acrostic at the top of this form.

2. Were X-rays taken?

- 1 X-rays were taken
0 Participant did not show up for appointment. Would not reschedule.
7 Participant refused x-rays at clinic visit.

V1XRAY

3. What is the MOST staff ID# for the X-ray technician?

V1XSID

4. Please indicate which views were taken and the settings used.

a. PA semiflexed view of right and left knee?

V1PA

1
 Yes

i. mAs setting . V1PAMAS

ii. Beam angle: **Check Data from Prior Visits Report to see which beam angle(s) was (were) best at baseline. Use best beam angle(s), and record angle(s) below. Mark all that apply.**

V1PA5 5°
V1PA10 10°
V1PA15 15°

0
 No

Comments: _____

b. Lateral view of right knee?

V1LR

1
 Yes

i. mAs setting . V1LRMAS

0
 No

Comments: _____

c. Lateral view of left knee?

V1LL

1
 Yes

i. mAs setting . V1LLMAS

0
 No

Comments: _____

Knee and Hip Examinations

MOST ID #	Acrostic	Staff ID#
<input type="text"/>	<input type="text"/>	<input type="text"/>



Right-side exams: Participant is lying on their left side.

Exam	"Is this tender or painful?"
<p>1. Trochanteric bursitis Has the participant had a <u>right</u> hip replacement? <i>(Refer to Data from Prior Visits Report.)</i></p> <p><input type="radio"/> No <input checked="" type="radio"/> Yes</p> <p><input type="radio"/> Yes</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 100px;"> Do NOT perform <u>right</u> trochanteric bursitis exam. </div>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused</p> <p style="text-align: center; color: blue; font-weight: bold;">1 0 8 7</p> <p style="text-align: center; color: blue; font-weight: bold;">V1PN1R</p>
<p>2. Iliotibial band</p> <p><input checked="" type="radio"/> Yes <input type="radio"/> No</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused</p> <p style="text-align: center; color: blue; font-weight: bold;">1 0 8 7</p> <p style="text-align: center; color: blue; font-weight: bold;">V1PN2R</p>

3. Has participant had right knee surgery where all or part of the joint was replaced?
(Interviewer Note: Refer to Data from Prior Visits Report.)

Yes No

Yes

Go to page 14, Question #9.

Knee and Hip Examinations

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



Right-side exams: *Participant is lying supine.*

Exam		"Is this tender or painful?"
4. Anserine bursa	<u>V1PN3R</u> →	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused
5. Medial tibiofemoral joint line	<u>V1PN4R</u> →	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused
6. Lateral tibiofemoral joint line	<u>V1PN5R</u> →	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused
7. Patellar tenderness	<u>V1PN6R</u> →	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused
8. Medial knee fat pad tenderness	<u>V1PN7R</u> →	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused
9. Hip internal rotation <u>pain</u> <input type="radio"/> No Has the participant had a <u>right</u> hip replacement? <input type="radio"/> Yes (Refer to Data from Prior Visits Report.)	→ "Is this tender or painful in your hip?" <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused <u>V1PN8R</u>	Where does it hurt? (Show Card # 1. Mark <u>all</u> that apply.)
Do NOT perform <u>right</u> hip pain exam.	1=YES	<input type="radio"/> 1 Groin/inside leg near hip <u>V1IRP1R</u> <input type="radio"/> 2 Outside of leg near hip <u>V1IRP2R</u> <input type="radio"/> 3 Front of leg near hip <u>V1IRP3R</u> <input type="radio"/> 4 Buttocks <u>V1IRP4R</u> <input type="radio"/> 5 Lower back <u>V1IRP5R</u> <input type="radio"/> Don't know <u>V1IRP6R</u>
10. Has participant had left knee surgery where all or part of the joint was replaced? (Interviewer Note: Refer to Data from Prior Visits Report.)	<input type="radio"/> Yes <input type="radio"/> No	Go to page 15, Question #16.

Knee and Hip Examinations

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



Left-side exams: *Participant is lying supine.*

Exam	"Is this tender or painful?"
11. Anserine bursa	<p>→ <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused</p> <p style="text-align: center;">V1PN9L</p>
12. Medial tibiofemoral joint line	<p>→ <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused</p> <p style="text-align: center;">V1PN10L</p>
13. Lateral tibiofemoral joint line	<p>→ <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused</p> <p style="text-align: center;">V1PN11L</p>
14. Patellar tenderness	<p>→ <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused</p> <p style="text-align: center;">V1PN12L</p>
15. Medial knee fat pad tenderness	<p>→ <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused</p> <p style="text-align: center;">V1PN13L</p>
<p>16. Hip internal rotation <u>pain</u> <input type="radio"/> No → "Is this tender or painful in your hip?"</p> <p>Has the participant had a <u>left</u> hip replacement? <input type="radio"/> Yes</p> <p><i>(Refer to Data from Prior Visits Report.)</i></p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> <p>Do NOT perform <u>left</u> hip pain exam.</p> </div> <p style="text-align: center; margin-top: 10px;">1=YES</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> <p>Where does it hurt? <i>(Show Card # 1, Mark <u>all</u> that apply.)</i></p> <p><input type="radio"/> 1 Groin/inside leg near hip V1IRP1L</p> <p><input type="radio"/> 2 Outside of leg near hip V1IRP2L</p> <p><input type="radio"/> 3 Front of leg near hip V1IRP3L</p> <p><input type="radio"/> 4 Buttocks V1IRP4L</p> <p><input type="radio"/> 5 Lower back V1IRP5L</p> <p><input type="radio"/> Don't know V1IRP6L</p> </div> <p style="text-align: center; margin-top: 10px;">V1PN14L</p>	

Knee and Hip Examinations

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



Left-side exams: Participant is lying on their right side.

Exam	"Is this tender or painful?"
<p>17. Trochanteric bursitis Has the participant had a left hip replacement? <i>(Refer to Data from Prior Visits Report.)</i></p> <p> <input type="radio"/> No → <input type="radio"/> Yes ↓ Do NOT perform <u>left</u> trochanteric bursitis exam. </p>	<p> <input checked="" type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused V1PN15L </p>
<p>18. Iliotibial band</p> <p>→</p>	<p> <input checked="" type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused V1PN16L </p>

Hip internal rotation exams: Participant is sitting.

Exam	How many degrees was the limit of motion?
<p>19. Right hip internal rotation Has the participant had a <u>right</u> hip replacement? <i>(Refer to Data from Prior Visits Report.)</i></p> <p> <input type="radio"/> No → <input type="radio"/> Yes ↓ Do NOT perform <u>right</u> hip exam. </p>	<p> <input type="text"/> <input type="text"/> <input type="text"/> degrees <input type="radio"/> Not done <input type="radio"/> Refused V1LOMR </p>
<p>20. Left hip internal rotation Has the participant had a <u>left</u> hip replacement? <i>(Refer to Data from Prior Visits Report.)</i></p> <p> <input type="radio"/> No → <input type="radio"/> Yes ↓ Do NOT perform <u>left</u> hip exam. </p>	<p> <input type="text"/> <input type="text"/> <input type="text"/> degrees <input type="radio"/> Not done <input type="radio"/> Refused V1LOML </p>

Knee and Hip Examinations

MOST ID #	Acrostic														
<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>								<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table>							



Tenderpoint exams: *Participant is sitting.*

21. Was pain present during either the right or left medial knee fat pad exams #8 and/or #15?

Yes No
 → Go to Eligibility for Physician Confirmatory Examination on next page.

V1EX19

Exam				"Is this tender or painful?"
a. Right elbow tenderpoint	→	1	0	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused V1PN19A
b. Left elbow tenderpoint	→	1	0	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused V1PN19B
c. Right trapezius tenderpoint	→	1	0	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused V1PN19C
d. Left trapezius tenderpoint	→	1	0	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused V1PN19D

Knee and Hip Examinations

MOST ID #	Acrostic	Staff ID#
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>



Eligibility for Physician Confirmatory Examination

I. RIGHT hip exam

Are one or more of the following conditions met?

- *Exam #9 Pain location 1 or 3 are marked, or
- *Exam #19 degree of motion is less than 105 degrees.

Yes

No

Go to II.

Was the participant seen in clinic because they had right knee pain?
(**Examiner Note: Refer to Data from Prior Visits Report.**)

Yes

No

Go to II.

Skip II, III, and IV and refer for physician exam.

II. LEFT hip exam

Are one or more of the following conditions met?

- *Exam #16 Pain location 1 or 3 are marked, or
- *Exam #20 degree of motion is less than 105 degrees.

Yes

No

Go to III.

Was the participant seen in clinic because they had left knee pain?
(**Examiner Note: Refer to Data from Prior Visits Report.**)

Yes

No

Go to III.

Skip III and IV and refer for physician exam.

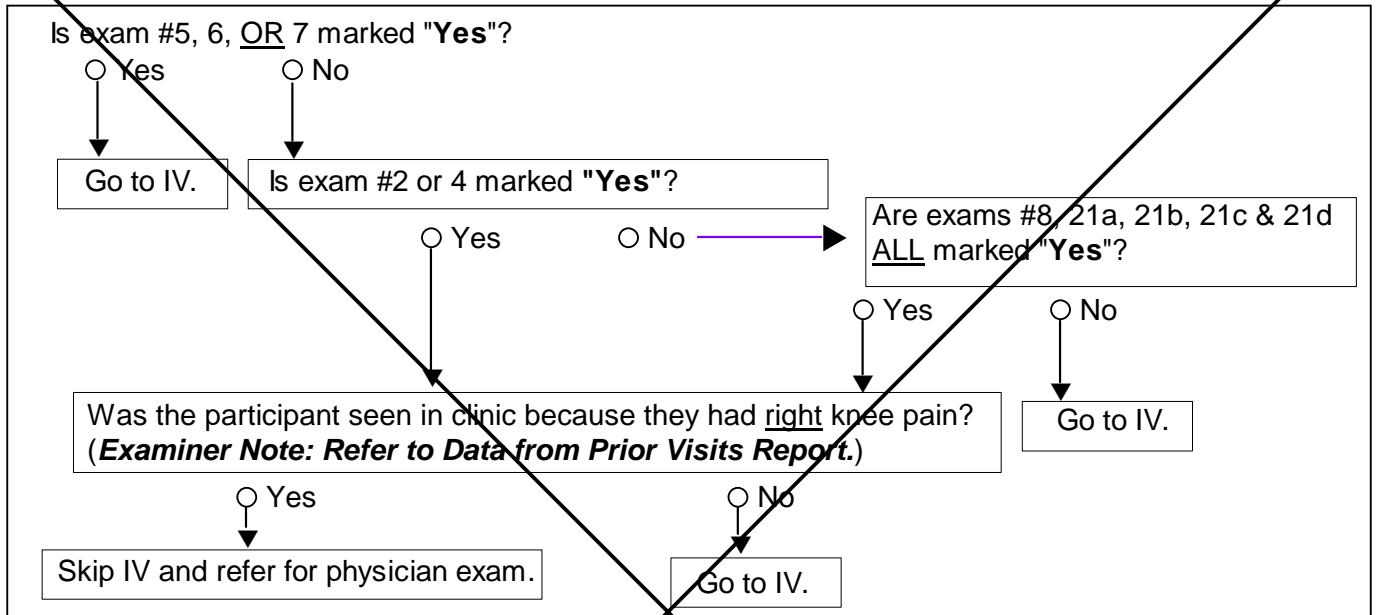
Knee and Hip Examinations

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

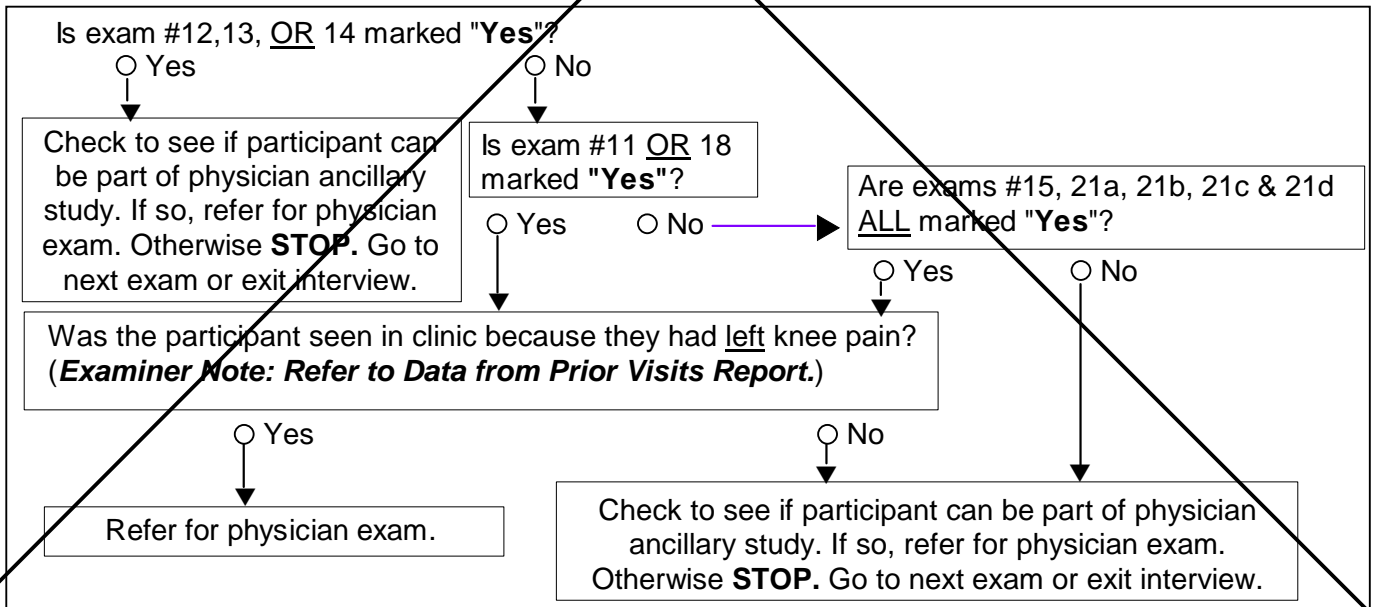


Eligibility for Physician Confirmatory Examination

III. RIGHT knee exam



IV. LEFT knee exam



Physician Confirmatory Examinations First Follow-up Visit



MOST ID #	Acrostic	Date Form Completed																									
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		Month		Day		Year																					

Right Knee Pain

1. When you have right knee pain, where does it usually hurt?
(Examiner Note: Have participant point to their own leg when answering this question. Mark all areas that apply.)

RIGHT KNEE

Mark all areas that apply.

1=YES

MD1KP1R 1

MD1KP2R 2

MD1KP3R 3

MD1KP4R 4

MD1KP5R 5

MD1KP6R 6

MD1KP7R 7

MD1KP8R 8

MD1KPR

0 No pain in right knee

8 Don't know

7 Refused

1 (if any in 1-8 above marked)

Physician Confirmatory Examinations



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Left Knee Pain

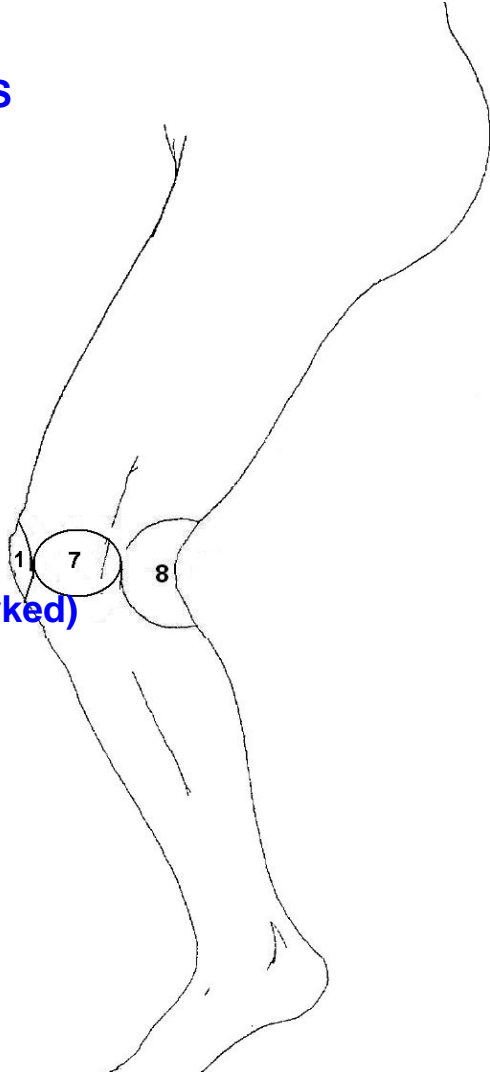
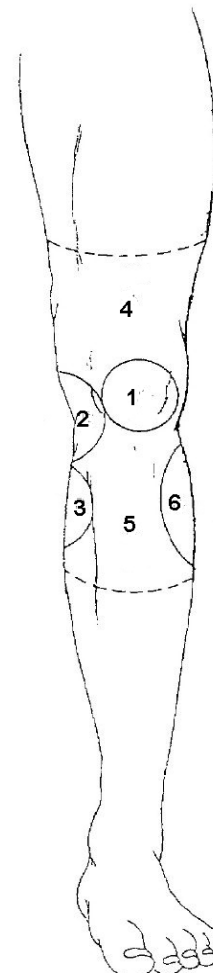
2. When you have left knee pain, where does it usually hurt?
 (Examiner Note: Have participant point to their own leg when answering this question. Mark all areas that apply.)

LEFT KNEE

Mark all areas that apply.

- 1 MD1KP1L
- 2 MD1KP2L
- 3 MD1KP3L
- 4 MD1KP4L
- 5 MD1KP5L
- 6 MD1KP6L
- 7 MD1KP7L
- 8 MD1KP8L

1=YES

MD1KPL

0 No pain in left knee

8 Don't know

7 Refused

1 (if any in 1-8 above marked)

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Right-side exams: *Participant is lying on their left side.*

Exam	"Is this tender or painful?"
<p>1. Trochanteric bursitis Has the participant had a <u>right</u> hip replacement? <i>(Refer to Data from Prior Visits Report.)</i></p> <div style="border: 1px solid black; padding: 5px; margin-left: 100px;"> Do NOT perform <u>right</u> trochanteric bursitis exam. </div>	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: right;"> No <input type="radio"/> ———> Yes <input type="radio"/> </div> <div style="text-align: center;"> <p> <input checked="" type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused </p> <p style="color: blue; font-weight: bold; font-size: 1.2em;">MD1PN1R</p> </div> </div>
<p>2. Iliotibial band</p>	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: right;"> <p>—————></p> </div> <div style="text-align: center;"> <p> <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused </p> <p style="color: blue; font-weight: bold; font-size: 1.2em;">MD1PN2R</p> </div> </div>

3. Has participant had right knee surgery where all or part of the joint was replaced?
(Interviewer Note: Refer to Data from Prior Visits Report.)

Yes No

Go to page 21, Question #9.

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MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



Right-side exams: *Participant is lying supine.*

Exam	"Is this tender or painful?"
4. Anserine bursa	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN3R
5. Medial tibiofemoral joint line	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN4R
6. Lateral tibiofemoral joint line	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN5R
7. Patellar tenderness	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN6R
8. Medial knee fat pad tenderness	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN7R
9. Hip internal rotation <u>pain</u> <input type="radio"/> No Has the participant had a <u>right</u> hip replacement? <i>(Refer to Data from Prior Visits Report.)</i>	"Is this tender or painful in your hip?" <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN8R
<input type="radio"/> Yes <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 20px;"> Do NOT perform <u>right</u> hip pain exam. </div>	<div style="border: 1px solid black; padding: 5px; margin-left: 20px;"> Where does it hurt? (Show Card # 1. Mark all that apply.) </div>
1=YES	<input type="radio"/> 1 Groin/inside leg near hip MD1IRP1R <input type="radio"/> 2 Outside of leg near hip MD1IRP2R <input type="radio"/> 3 Front of leg near hip MD1IRP3R <input type="radio"/> 4 Buttocks MD1IRP4R <input type="radio"/> 5 Lower back MD1IRP5R <input type="radio"/> Don't know MD1IRP6R
10. Has participant had left knee surgery where all or part of the joint was replaced? <i>(Interviewer Note: Refer to Data from Prior Visits Report.)</i>	
<input type="radio"/> Yes <input type="radio"/> No <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 20px;"> Go to page 22, Question #16. </div>	

Physician Confirmatory Examinations

MOST ID #	Acrostic
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>



Left-side exams: *Participant is lying supine.*

Exam	"Is this tender or painful?"
11. Anserine bursa	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN9L
12. Medial tibiofemoral joint line	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN10L
13. Lateral tibiofemoral joint line	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN11L
14. Patellar tenderness	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN12L
15. Medial knee fat pad tenderness	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN13L
16. Hip internal rotation <u>pain</u> <input type="radio"/> No <input type="radio"/> Yes Has the participant had a <u>left</u> hip replacement? <i>(Refer to Data from Prior Visits Report.)</i>	"Is this tender or painful in your hip?" <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused MD1PN14L
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 100px;"> Do NOT perform <u>left</u> hip pain exam. </div>	<div style="border: 1px solid black; padding: 5px; margin-left: 100px;"> Where does it hurt? (Show Card # 1, Mark <u>all</u> that apply.) <ul style="list-style-type: none"> <input type="radio"/> 1 Groin/inside leg near hip MD1IRP1L <input type="radio"/> 2 Outside of leg near hip MD1IRP2L <input type="radio"/> 3 Front of leg near hip MD1IRP3L <input type="radio"/> 4 Buttocks MD1IRP4L <input type="radio"/> 5 Lower back MD1IRP5L <input type="radio"/> Don't know MD1IRP6L </div>

Physician Confirmatory Examinations

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Left-side exams: Participant is lying on their right side.

Exam	"Is this tender or painful?"
<p>17. Trochanteric bursitis</p> <p>Has the participant had a left hip replacement? <i>(Refer to Data from Prior Visits Report.)</i></p> <p> <input checked="" type="radio"/> No → <input type="radio"/> Yes </p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 100px;"> Do NOT perform <u>left</u> trochanteric bursitis exam. </div>	<p> <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused </p> <p style="text-align: center; color: blue; font-weight: bold;">MD1PN15L</p>
<p>18. Iliotibial band</p> <p>→</p>	<p> <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused </p> <p style="text-align: center; color: blue; font-weight: bold;">MD1PN16L</p>

Hip internal rotation exams: Participant is sitting.

Exam	How many degrees was the limit of motion?
<p>19. Right hip internal rotation</p> <p>Has the participant had a <u>right</u> hip replacement? <i>(Refer to Data from Prior Visits Report.)</i></p> <p> <input checked="" type="radio"/> No → <input type="radio"/> Yes </p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 100px;"> Do NOT perform <u>right</u> hip exam. </div>	<p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> degrees <input type="radio"/> Not done <input type="radio"/> Refused </p> <p style="text-align: center; color: blue; font-weight: bold;">MD1LOMR</p>
<p>20. Left hip internal rotation</p> <p>Has the participant had a <u>left</u> hip replacement? <i>(Refer to Data from Prior Visits Report.)</i></p> <p> <input checked="" type="radio"/> No → <input type="radio"/> Yes </p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 100px;"> Do NOT perform <u>left</u> hip exam. </div>	<p> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 30px; height: 20px; border: 1px solid black;" type="text"/> degrees <input type="radio"/> Not done <input type="radio"/> Refused </p> <p style="text-align: center; color: blue; font-weight: bold;">MD1LOML</p>

Physician Confirmatory Examinations

MOST ID #	Acrostic
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Tenderpoint exams: *Participant is sitting.*

21. Was pain present during either the right or left medial knee fat pad exams #8 and/or #15?

Yes No

MD1EX19

Exam	"Is this tender or painful?"
a. Right elbow tenderpoint	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused MD1PN19A
b. Left elbow tenderpoint	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused MD1PN19B
c. Right trapezius tenderpoint	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused MD1PN19C
d. Left trapezius tenderpoint	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused MD1PN19D