



MOST PUBLIC DATA RELEASE
ANNOTATED DATA COLLECTION FORMS
30-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 Second 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="text"/> <input type="text"/>	1 <input type="radio"/> SITE 1 2 <input type="radio"/> SITE 2
Month	Day	Year	

MOSTID

ACROSTIC

V2_TIDIFF

SITE

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?

V212MR

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?

1 ☐ Yes

0 ☐ No

8 ☐ Don't know

Go to Question #3.

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

V230DR

1 ☐ Yes

0 ☐ No

8 ☐ Don't know/Refused

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

V230MSR

1 ☐ Yes

0 ☐ No

8 ☐ Don't know

Go to Question #3.

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"/> <input type="text"/>



Knee Symptoms

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?
- V212ML** 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?

- V212MSL** 1 ☐ Yes 0 ☐ No 8 ☐ 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?
- V230DL** 1 ☐ Yes 0 ☐ No 8 ☐ Don't know/Refused

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

- V230MSL** 1 ☐ Yes 0 ☐ No 8 ☐ Don't know

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?
- V2LA** 1 ☐ Yes 0 ☐ No 8 ☐ Don't know/Refused

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

V2LADAY days

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?

- 1 ☐ Yes 0 ☐ No 8 ☐ Don't know

V2AVOIDT

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"/>	<input type="text"/>



6. Interviewer Note: Refer to Data from Prior Visits Report. Was participant eligible for MRI at prior visit(s)?

☐ Yes

☐ No

Go to Page 5, Question #11 and mark "No."

The next few questions are about MRI eligibility.

6a. Since your last MRI scan at the MOST clinic on ____/____/____ (from Data from Prior Visits Report), have you had any surgery or anything implanted in your body?

☐ Yes

☐ No

☐ Don't know/Refused

6b. 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 Notes:

- 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.

- Fill out an Event Notification Form for Knee/Hip Replacement if participant reports a knee or hip replacement.

6c. 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 dental implant or dentures, magnetic eye implant, or other magnetic device	<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

6d. Interviewer Note:

Are any of the above items in Question #6c marked "Yes" or "Don't Know/Refused"?

☐ Yes

Not eligible for MRI. Go to Page 5, Question #11 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"/>



6e. 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 (<i>men only</i>)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
vii. Heart valve	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused

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

9. **Interviewer Note:**
Are any of the above items in Question #6e or Questions #7-8 marked "Yes" or "Don't Know/Refused"?

☐ Yes
↓

☐ No

9a. 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 5, Question #11 and mark "No."

MRI Eligibility

MOST ID #	Acrostic
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10. Interviewer Note: Is there any other reason why this participant would not be eligible for an MRI? (e.g., participant has had both knees replaced)

☐ Yes

☐ No

What is the reason?

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

11. Interviewer Note: Is the participant eligible for an MRI scan? (Refer to Questions #6, #9-9a, and #10.)

☐ Yes

☐ No

Mark "CLINIC VISIT-WITH MRI" in Box A on page 8. Then go to Question #12.

Mark "CLINIC VISIT-NO MRI" in Box A on page 8. Then go to Page 6, Question #13.

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

☐ Yes

☐ No

☐ Don't know/Refused

12a. 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 6, Question #13. Do not scan today's Telephone Interview forms. Re-contact 2 months after surgery to reassess eligibility.

MOST ID #	Acrostic
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Contact Information

- 13.** 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.

- 14.** 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.

- 15.** 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"/>



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

☐ Yes

☐ No → Go to Question #17

16a. 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

Go to Question #18

Go to Question #18

17. 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.

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

☐ Yes

☐ No → Go to Question #19

18a. 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

Go to next page

Go to next page

19. 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.

Clinic Visit Eligibility

MOST ID #	Acrostic
<div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>	<div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div>



BOX A

☐ CLINIC VISIT - WITH MRI

"Thank you for your time and for answering our questions. We'd like to schedule you for a clinic visit. Before I schedule your appointment, do you have any questions?" (**Read script from Operations Manual for scheduling a clinic visit with MRI.**)

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

☐ CLINIC VISIT - NO MRI

"Thank you for your time and for answering our questions. We'd like to schedule you for a clinic visit. Before I schedule your appointment, do you have any questions?" (**Read script from Operations Manual for scheduling a clinic visit with no MRI.**)

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

☐ 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. Do you have any questions?"

Follow protocol for participants who are not interested in coming in for clinic visit.

Self-Administered Questionnaire - Home Second Follow-up Visit



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

Joint Pain, Aching, and Stiffness

1. On most days, do you have pain, aching, or stiffness in any joints?

☐ 1 Yes

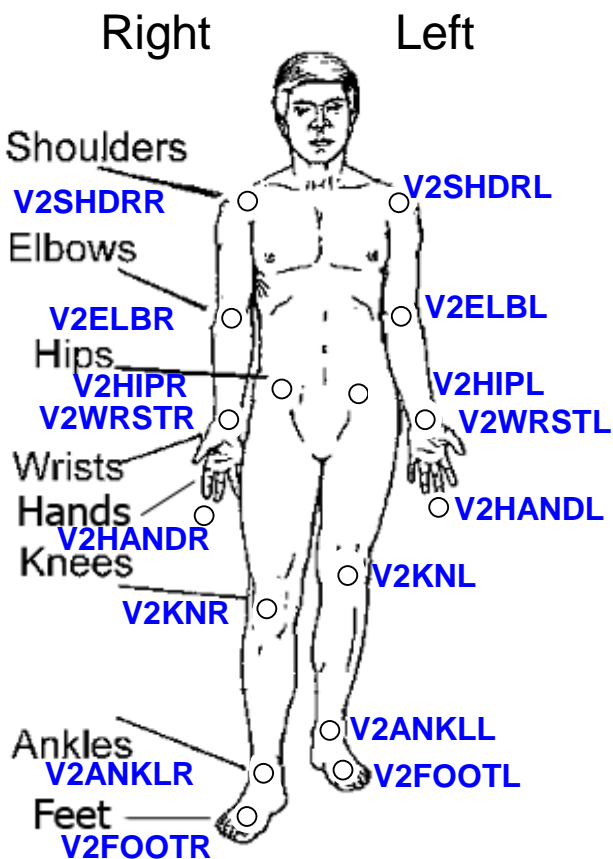
☐ 0 No

☐ 8 Don't know

V2JPAIN

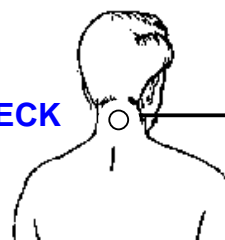
Go to Page #2, Question #2.

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.)



V2NECK

Neck



V2_WSPA

V2_WSPB

V2_WSPC

1=YES

Back Pain and Function

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"/>



2. During the **past 30 days**, have you had any back pain?
- V2PAIN 1 ☐ Yes 0 ☐ No 8 ☐ Don't know

Go to Page 3, Question #3.

- a. How often were you bothered by back pain in the **past 30 days**?

(Mark only one response.)

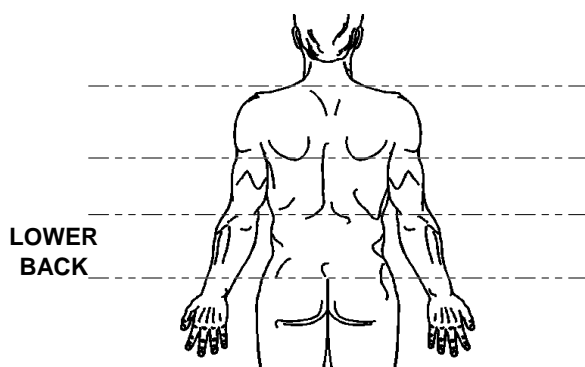
- 1 ☐ All of the time 2 ☐ Most of the time 3 ☐ Some of the time 4 ☐ Rarely 5 ☐ Never

- b. When you have had back pain, how bad was it on average?

- 1 ☐ Mild 2 ☐ Moderate 3 ☐ Severe

- c. In what part or parts of your back is the pain usually located?

(Mark all areas on the back that apply with an X)



CLINIC
USE ONLY

- V2NK ☐ NK
V2UB ☐ UB
V2MB ☐ MB
V2LB ☐ LB
V2BK ☐ BK

1=YES

V2_LBP

- d. During the **past 30 days**, have you limited your activities because of back pain?

- 1 ☐ Yes 0 ☐ No → Go to Page 3, Question #3.

- di. How many days did you stay in bed because of your back?

V2BDDAY

<input type="text"/>	<input type="text"/>
----------------------	----------------------

days

- dii. How many days did you limit your activities because of your back?

(Do not include days in bed.)

V2BPLAD

<input type="text"/>	<input type="text"/>
----------------------	----------------------

days

Arthritis Diagnosis

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"/>



3. Since your first visit to the MOST clinic in _____, has your doctor told you that you have arthritis?

V2ARTH

1 ☐ Yes

0 ☐ No

8 ☐ Don't know

Go to Page 4, Question #4.

What kind of arthritis did your doctor say it was? Did your doctor say you had...
(Please answer "Yes," "No," or "Don't know" for all questions below.)

V2RA	a. Rheumatoid arthritis?	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
V2KNOA	b. Osteoarthritis or degenerative arthritis in your <u>knee</u> ?	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
V2HPOA	c. Osteoarthritis or degenerative arthritis in your <u>hip</u> ?	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
V2HFOA	d. Osteoarthritis or degenerative arthritis in your <u>hand or fingers</u> ?	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
V2OJOA	e. Osteoarthritis or degenerative arthritis in some <u>other joint</u> ?	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
V2GOUT	f. Gout?	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
V2OTH	g. Some other type of arthritis? (Please specify: _____)	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know

Arthritis Medications

MOST ID #						Acrostic			



4. Are you taking any of the following medications for joint pain or arthritis?

- ◊ Aspirin
- ◊ Advil or Motrin (Ibuprofen)
- ◊ Aleve or Naprosyn (Naproxen)
- ◊ Celebrex (Celecoxib)
- ◊ Tylenol (Acetaminophen)

Others:

- ◊ Arthrotec (Diclofenac with misoprostol)
- ◊ Cataflam (Diclofenac)
- ◊ Indocin (Indomethacin)
- ◊ Lodine (Etodolac)
- ◊ Mobic (Meloxicam)
- ◊ Orudis (Ketoprofen)
- ◊ Relafen (Nabumetone)
- ◊ Voltaren (Diclofenac)

1
☐ Yes

0
☐ No

8
☐ Don't know **V2ARTHRX**

Go to Page 5, Question #5.

a. How often do you take any of these medications?

- 5**
☐ More than once a day **V2MOFT**
- 4**
☐ Once a day
- 3**
☐ Three to five times a week
- 2**
☐ Once or twice a week
- 1**
☐ Less than once a week

Arthritis Medications

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"/>



5. Are you taking any of the following stronger medications for joint pain or arthritis?

- ◊ Darvocet-N (Propoxyphene with acetaminophen)
- ◊ Duragesic (Fentanyl)
- ◊ Endocet (Oxycodone with acetaminophen)
- ◊ Lorcet (Hydrocodone with acetaminophen)
- ◊ MS Contin (Morphine sulfate)
- ◊ Norco (Hydrocodone with acetaminophen)
- ◊ OxyContin (Oxycodone)
- ◊ Percocet (Oxycodone with acetaminophen)
- ◊ Tylenol with codeine (Acetaminophen with codeine)
- ◊ Ultracet (Tramadol with acetaminophen)
- ◊ Ultram (Tramadol)
- ◊ Vicodin (Hydrocodone with acetaminophen)
- ◊ Vicoprofen (Hydrocodone with ibuprofen)

1
☐ Yes

0
☐ No

8
☐ Don't know **V2SMED**

Go to Page 6, Question #6.

a. How often do you take any of these medications?

5 ☐ More than once a day **V2SMOFT**

4 ☐ Once a day

3 ☐ Three to five times a week

2 ☐ Once or twice a week

1 ☐ Less than once a week

MOST ID #	Acrostic
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Health History and Medical Conditions

6. Have you ever had a heart attack?

1
☐ Yes

0
☐ No

8
☐ Don't know

V2HRTAT

Go to Question #7.

a. How old were you when you had your most recent heart attack?

years old

V2AYO

7. Have you ever had an operation to unclog or bypass the arteries in your heart?

1
☐ Yes

0
☐ No

8
☐ Don't know

V2UNCLOG

Go to Question #8.

a. How old were you when you had your most recent operation to unclog or bypass the arteries in your heart?

years old

V2HOPYO

8. Have you ever been treated for heart failure? (You may have been short of breath and the doctor may have told you that you had fluid in your lungs or that your heart was not pumping well.)

1
☐ Yes

0
☐ No

8
☐ Don't know

V2HRTFA

Go to Page 7, Question #9.

a. How old were you when you had your most recent treatment for heart failure?

years old

V2TYO

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 History and Medical Conditions

9. Have you ever had an operation to unclog or bypass the arteries in your legs?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2BYPASS

Go to Question #10.

a. How old were you when you had your most recent operation to unclog or bypass the arteries in your legs?

years old

V2LOPYO

10. Have you had a stroke, cerebrovascular accident, blood clot or bleeding in the brain, or transient ischemic attack (TIA)?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2STROKE

Go to Question #11.

a. Do you have difficulty moving an arm or leg as a result of the stroke or cerebrovascular accident?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2MOVE

11. Do you have asthma?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2ASTHMA

Go to Page 8, Question #12.

a. Do you take medicines for your asthma?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2ASTRX

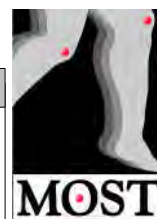
b. When do you usually take the medicine? (*Please mark one.*)

☐ 1 Only with flare-ups of my asthma

☐ 2 Regularly, even when I'm not having a flare-up

V2AWHEN

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"/>



Health History and Medical Conditions

12. Do you have emphysema, chronic bronchitis, or chronic obstructive lung disease?

1
☐ Yes

0
☐ No

8
☐ Don't know

V2COPD

Go to Question #13.

a. Do you take medicines for your lung disease?

1
☐ Yes

0
☐ No

8
☐ Don't know

V2LUNRX

b. When do you usually take the medicine? (*Please mark one.*)

1
☐ Only with flare-ups of my emphysema, bronchitis or COPD

2
☐ Regularly, even when I'm not having a flare-up

V2LWHEN

13. Do you have stomach ulcers, or peptic ulcer disease?

1
☐ Yes

0
☐ No

8
☐ Don't know

V2ULCER

Go to Page 9, Question #14.

a. Has this condition been diagnosed by endoscopy (where a doctor looks into your stomach through a scope) or an upper GI or barium swallow study (where you swallow chalky dye and then x-rays are taken)?

1
☐ Yes

0
☐ No

8
☐ Don't know

V2ULCDX

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"/>



Health History and Medical Conditions

14. Do you have diabetes (high blood sugar)?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2DIABT

Go to Question #15.

a. How has your diabetes been treated?
(Please mark all that apply.)

V2DIET ☐ modifying my diet

V2DRX ☐ medications taken by mouth

V2INJ ☐ insulin injections

V2NONE ☐ not treated

1=YES

b. Has the diabetes caused any of the following problems?
(Please mark all that apply.)

V2KID ☐ Problems with your kidneys

V2DEYE ☐ Problems with your eyes, treated by an ophthalmologist

V2DDK ☐ Has not caused problems

15. Have you ever had serious problems with your kidneys?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2KIDNY

Go to Page 10, Question #16.

a. Kidney problems: (Please mark all that apply.)

V2POORF ☐ Poor kidney function (blood tests show high creatinine)

V2TRANS ☐ Have received a kidney transplantation

V2DIALY ☐ Have used hemodialysis or peritoneal dialysis

V2KOTR ☐ Other (Please specify: _____)

V2DK ☐ Don't know

1=YES

b. How old were you when you had your most recent serious problems with your kidneys?

<input type="text"/>	<input type="text"/>
----------------------	----------------------

years old

V2KYO

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"/>



17. Since your last telephone interview in [__], did a doctor tell you that you broke or fractured a bone?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know/Refused **V2BONE**

Go to Question #18.

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

☐ 1 Yes

☐ 0 No

☐ 8 Don't know/Refused

V2FXHIP

b. 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

V2SPINE

V2_FXHIPSP

18. During the past 12 months, have you fallen and landed on the floor or ground?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know/Refused **V2FALLG**

Go to Page 12, Question #19.

a. How many times have you fallen in the past 12 months? If you are unsure, please make your best guess.

☐ 1 One

☐ 2 Two or three

☐ 3 Four or five

☐ 4 Six or more

☐ 8 Don't know

V2FALLT

Current Employment

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"/>



19. Do you currently do any amount of work for pay?
(Also mark "Yes" if you are self-employed or you are on a temporary leave from work and expect to return to work within 6 months.)

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2PAY

Go to Question #20.

- a. Do you do at least 15 hours of unpaid work per week for a business or farm owned by a member of your family?

(Work that you do to care for family members or as a volunteer does not apply.)

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2NOPAY

Go to Question #20.

- b. Are you not working due at least in part to your health?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2HLTH

Go to Page 13, Question #22

20. When you worked over the past year, on average how many hours a week did you usually work? **(Include any overtime hours you usually worked.)**

<input type="text"/>	<input type="text"/>
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Number of hours worked per week

V2HRSWK

21. How many half or full workdays did you miss in the past 3 months because of knee pain, aching or stiffness? **(Please write in the number of days; if none, put 0.)**

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Number of days missed in the past 3 months

V2MIS



MOST ID #						Acrostic			

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	
22. Visiting friends and family in their homes	5 ○	4 ○	3 ○	2 ○	1 ○	V2FDI1
23. Providing care or assistance to others. This may include providing personal care, transportation, and running errands for family members or friends.	5 ○	4 ○	3 ○	2 ○	1 ○	V2FDI2
24. Taking care of the inside of your home. This includes managing and taking responsibility for homemaking, laundry, housecleaning and minor household repairs.	5 ○	4 ○	3 ○	2 ○	1 ○	V2FDI3
25. Working at a volunteer job outside your home.	5 ○	4 ○	3 ○	2 ○	1 ○	V2FDI4
26. Taking part in active recreation. This may include bowling, golf, tennis, hiking, jogging, or swimming.	5 ○	4 ○	3 ○	2 ○	1 ○	V2FDI5
27. Traveling out of town for at least an overnight stay.	5 ○	4 ○	3 ○	2 ○	1 ○	V2FDI6
28. Taking part in a regular fitness program. This may include walking for exercise, stationary biking, weight lifting, or exercise classes.	5 ○	4 ○	3 ○	2 ○	1 ○	V2FDI7
29. Going out with others to public places such as restaurants or movies.	5 ○	4 ○	3 ○	2 ○	1 ○	V2FDI8

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"/>



To what extent do you feel limited in...?	Not at all	A little	Somewhat	A lot	Completely	
30. 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"/>	V2FDI9
31. 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"/>	V2FDI10
32. 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"/>	V2FDI11
33. 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"/>	V2FDI12

V2LLDIIR



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"/> <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.

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

- V2SF1**
- 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
35. <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, V2SF2 bowling, or playing golf	1 <input type="radio"/>	2 <input type="radio"/>	0 <input type="radio"/>
36. Climbing <u>several</u> flights of stairs V2SF3	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?

37. <u>Accomplished less</u> than you would like V2SF4	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
38. Were limited in the <u>kind</u> of work or other activities V2SF5	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)?

39. <u>Accomplished less</u> than you would like V2SF6	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
40. Didn't do work or other activities as <u>carefully</u> as usual V2SF7	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know

MOST ID #						Acrostic			



Health Survey

41. 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.)**

V2SF8

- ☐ 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
42. Have you felt calm and peaceful? V2SF9	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> 0
43. Did you have a lot of energy? V2SF10	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> 0
44. Have you felt downhearted and blue? V2SF11	<input type="radio"/> 5	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> 0

45. 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.)**

V2SF12

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

V2SF12MM

V2SF12MP



MOST ID #						Acrostic			

Health Survey

46. For each of the following statements, think about your feelings during the **past 7 days**. Mark the response that best describes your feelings:

Rarely or None of the time; Some of the time; Much of the time; Most or All of the time.

	Rarely or None of the time (<1 day)	Some of the time (1-2 days)	Much of the time (3-4 days)	Most or All of the time
a. I was bothered by things that usually don't bother me.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 V2CESDA
b. I did not feel like eating: my appetite was poor.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 V2CESDB
c. I felt that I could not shake off the blues even with help from my family and friends.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 V2CESDC
d. I felt that I was just as good as other people.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 V2CESDD
e. I had trouble keeping my mind on what I was doing.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 V2CESDE
f. I was depressed.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 V2CESDF
g. I felt that everything I did was an effort.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 V2CESDG
h. I felt hopeful about the future.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 V2CESDH
i. I thought my life had been a failure.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 V2CESDI
j. I felt fearful.	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4 V2CESDJ



MOST ID #						Acrostic			

Health Survey

46. For each of the following statements, think about your feelings during the **past 7 days**. Mark the response that best describes your feelings:

Rarely or None of the time; Some of the time; Much of the time; Most or All of the time.

	Rarely or None of the time (<1 day)	Some of the time (1-2 days)	Much of the time (3-4 days)	Most or All of the time	
k. My sleep was restless.	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁴ <input type="radio"/>	V2CESDK
l. I was happy.	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁴ <input type="radio"/>	V2CESDL
m. It seemed that I talked less than usual.	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁴ <input type="radio"/>	V2CESDM
n. I felt lonely.	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁴ <input type="radio"/>	V2CESDN
o. People were unfriendly.	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁴ <input type="radio"/>	V2CESDO
p. I enjoyed life.	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁴ <input type="radio"/>	V2CESDP
q. I had crying spells.	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁴ <input type="radio"/>	V2CESDQ
r. I felt sad.	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁴ <input type="radio"/>	V2CESDR
s. I felt that people disliked me.	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁴ <input type="radio"/>	V2CESDS
t. I could not get going.	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁴ <input type="radio"/>	V2CESDT

V2CES_D

V2_DEP



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 page 1, the bottom of page 2, the top and bottom of page 3, and all of pages 4, 5, 7, and 8 of the MOST Second 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	V2Q1KR	V2Q1KL
Up stairs	V2UPR	V2UPL
Down stairs	V2DOWNR	V2DOWNL
Stairs (calculated)	V2Q2KR	V2Q2KL
In bed	V2Q3KR	V2Q3KL
Sit or lie down	V2Q4KR	V2Q4KL
Standing	V2Q5KR	V2Q5KL

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: V2UPR, V2UPL, V2DOWNR, and V2DOWNL. “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	V2WOPNKR	V2WOPNKL

(Note: page 1, the bottom of page 2, the top and bottom of page 3, and all of pages 4, 5, 7, and 8 of the MOST Second Follow-up Self-Administered Questionnaire – Clinic are not being displayed)

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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	V2Q6KR	V2Q6KL
Later in day	V2Q7KR	V2Q7KL

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	V2WOSTKR	V2WOSTKL

Disability

The individual items in the disability subscale are:

<u>Activity</u>	<u>Variable (either knee)</u>
Down stairs	V2Q8K
Up stairs	V2Q9K
Stand from sitting	V2Q10K
Standing	V2Q11K
Bending	V2Q12K
Walking	V2Q13K
In car/out of car	V2Q14K
Shopping	V2Q15K
Socks on	V2Q16K
Get out of bed	V2Q17K
Socks off	V2Q18K
Lying down	V2Q19K
Bathing	V2Q20K
Sitting	V2Q21K
On/off toilet	V2Q22K
Heavy chores	V2Q23K
Light chores	V2Q24K

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: V2Q8K, V2Q9K, V2Q12K, V2Q15K, V2Q23K, and V2Q24K. “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	V2WOPASK

(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)

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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	V2WOTOTR	V2WOTOTL

Hip pain

The individual items in the pain subscale are:

<u>Activity</u>	<u>Variable (right knee)</u>	<u>Variable (left knee)</u>
Walking	V2Q1HR	V2Q1HL
Up/down stairs	V2Q2HR	V2Q2HL
In bed	V2Q3HR	V2Q3HL
Sit or lie down	V2Q4HR	V2Q4HL
Standing	V2Q5HR	V2Q5HL
Socks on	V2Q6HR	V2Q6HL
In chair/out of chair	V2Q7HR	V2Q7HL
In car/out of car	V2Q8HR	V2Q8HL

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: V2Q2HR and V2Q2HL. "Don't do" is set to missing.

The pain subscale scores are calculated for the right and left hip separately. V2WOPNHR and V2WOPNHL are standard calculations and V2WOPHRM and V2WOPHLM 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	V2WOPNHR	V2WOPNHL
Pain/disability subscale scores	V2WOPHRM	V2WOPHLM

(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 Second Follow up
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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)

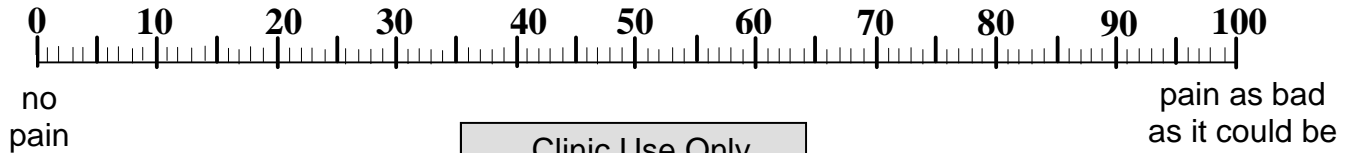
Most Second Follow up
Self-Administered Questionnaire – Clinic

Knee Symptoms

MOST ID #						Acrostic			



2. 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")



Clinic Use Only		

V2VASKR

Note: WOMAC© was removed from this page. See "Scoring for WOMAC©" documentation on page [27].

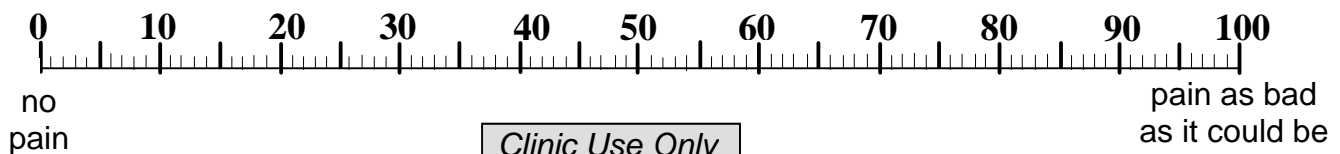
Knee Symptoms

MOST ID #						Acrostic		



Note: WOMAC© was removed from this page. See "Scoring for WOMAC©" documentation on page [27].

6. 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")



Clinic Use Only		

V2VASKL

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**.

10. QUESTION: What degree of difficulty do you have due to pain, discomfort or arthritis in your knee(s)?							
a. Squatting	0 <input type="radio"/> none	1 <input type="radio"/> mild	2 <input type="radio"/> moderate	3 <input type="radio"/> severe	4 <input type="radio"/> extreme	5 <input type="radio"/> don't do	V2SP1K
b. Running/jogging	0 <input type="radio"/> none	1 <input type="radio"/> mild	2 <input type="radio"/> moderate	3 <input type="radio"/> severe	4 <input type="radio"/> extreme	5 <input type="radio"/> don't do	V2SP2K
c. Jumping	0 <input type="radio"/> none	1 <input type="radio"/> mild	2 <input type="radio"/> moderate	3 <input type="radio"/> severe	4 <input type="radio"/> extreme	5 <input type="radio"/> don't do	V2SP3K
d. Twisting/pivoting on your knees	0 <input type="radio"/> none	1 <input type="radio"/> mild	2 <input type="radio"/> moderate	3 <input type="radio"/> severe	4 <input type="radio"/> extreme	5 <input type="radio"/> don't do	V2SP4K
e. Kneeling	0 <input type="radio"/> none	1 <input type="radio"/> mild	2 <input type="radio"/> moderate	3 <input type="radio"/> severe	4 <input type="radio"/> extreme	5 <input type="radio"/> don't do	V2SP5K

V2KOSSP

Second Follow-up Clinic Visit Workbook

Procedure Checklist

MOST ID #	Acrostic	Date Form Completed	Staff ID#
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V2_DATEDIFF

Measurement	Page #	Completed	Partially completed	Participant refused	Not done/ Not applicable
1. Was Self-administered Home Questionnaire completed/checked?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Was Self-administered Clinic Questionnaire completed/checked?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Was Clinic Interview administered?	2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Medication Inventory	17	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Blood Pressure	18	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Weight	19	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. 20-meter Walk	20	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Chair Stands	21	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Knee and Hip Examinations	23	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Knee X-ray	29	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. OrthOne 1.0 T Knee MRI	30	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Urine collection	36	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Phlebotomy	37	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Laboratory Processing	38	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Completed	Scheduled	Participant refused	Not eligible/ Not applicable
15. 1.5 T Knee MRI		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Knee Symptoms

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



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?

V2KPN12R 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?

V2MNTHR 1 Yes 0 No 8 Don't know

Go to Question #3.

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

V2PN30R 1 Yes 0 No 8 Don't know/Refused

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

V2KPN30R 1 Yes 0 No 8 Don't know

Examiner Note: Record that participant has right knee pain on the Knee and Hip Exam form (Page 23, Question A in the Second Follow-up Clinic Visit Workbook), and then proceed to Question #3.

Go to Question #3.

V2R_FKP

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"/>



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?
- V2KPN12L** ☐ 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?

V2MNTHL ☐ 1 Yes ☐ 0 No ☐ 8 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?
- V2PN30L** ☐ 1 Yes ☐ 0 No ☐ 8 Don't know/Refused

Go to Question #5.

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

V2KPN30L ☐ 1 Yes ☐ 0 No ☐ 8 Don't know

Examiner Note: Record that participant has left knee pain on the Knee and Hip Exam form (Page 23, Question B in the Second Follow-up Clinic Visit Workbook), and then proceed to Question #5.

V2L_FKP

V2_FKPSX

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?
- V2KNLA** ☐ 1 Yes ☐ 0 No ☐ 8 Don't know/Refused

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

V2KNLAD

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?

V2AVOID ☐ 1 Yes ☐ 0 No ☐ 8 Don't know

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"/>



Knee Buckling

For the following questions, we are interested in knee buckling or your knee "giving way." Sometimes you may feel as if your knee is going to buckle but it doesn't actually do so. That does not count.

6. Has your knee buckled or given way at least once in the past 3 months?

V2KBUCK ¹ ☐ Yes ⁰ ☐ No ⁸ ☐ Don't know/Refused

Go to Question #11.

7. Which knee buckled or gave way at least once?

V2KBS ¹ ☐ Right knee ² ☐ Left knee ³ ☐ Both knees ⁸ ☐ Don't know which knee/Refused

8. Counting all times and both knees, how many times in the past 3 months have your knees buckled?

V2KBTOT ¹ ☐ 1 time
² ☐ 2 to 5 times
³ ☐ 6 to 10 times
⁴ ☐ 11 to 24 times
⁵ ☐ More than 24 times
⁸ ☐ Don't know/Refused

9. As a result of knee buckling or giving way, did you accidentally fall and hit the floor or ground?

V2FALL ¹ ☐ Yes ⁰ ☐ No ⁸ ☐ Don't know/Refused

10. In general, what were you doing when your knee(s) buckled?

(Examiner Note: Please mark all that apply.)

V2WLK ☐ Walking
^{1=YES} **V2STAIRB** ☐ Going up or down stairs
V2TWIST ☐ Twisting or turning
V2KBOT ☐ Other *(Please specify: _____)*
V2KBDK ☐ Don't know/Refused

MOST ID #	Acrostic
<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>	<div></div> <div></div> <div></div> <div></div>



Knee Injury

The next two questions are about knee injuries.

Right Knee

11. Since your last telephone interview in [month/year], have you injured your right knee badly enough to limit your ability to walk for at least two days?
(Examiner Note: Refer to Data from Prior Visits Report for month/year of last telephone interview).

1
☐ Yes

0
☐ No

8
☐ Don't know/Refused

V2LAR

Left Knee

12. Since your last telephone interview, have you injured your left knee badly enough to limit your ability to walk for at least two days?

1
☐ Yes

0
☐ No

8
☐ Don't know/Refused

V2LAL

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"/>



The next few questions are about knee surgery.

13. Since your last telephone interview, did you have any surgery in your right knee?

☐ Yes

☐ No

☐ Don't know/Refused

V2SURGR

Go to Question #15.

14. Since your first 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?

☐ Yes

☐ No

☐ Don't know

V2ARTR

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

☐ Yes

☐ No

☐ Don't know

V2MENR

c. Ligament repair in your right knee?

☐ Yes

☐ No

☐ Don't know

V2LIGR

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

☐ Yes

☐ No

☐ Don't know

V23KNRR

Examiner Note: Please complete the Event Notification Form and mark Right Total Knee Replacement; record that participant had right knee replacement on Page 23, Question G; and then go to Question #14e below.

e. Another kind of surgery in your right knee?

☐ Yes

☐ No

☐ Don't know

V2SOTHR

f. i. Are any of the answers for Questions #14a-14e above marked "Yes"?

☐ Yes

☐ No

V23SUMYR

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

V2MIMPR

Examiner Note: Record that participant has metal implants in right knee on the OrthOne 1.0 T form (Page 32, Question #8 in the Second Follow-up Clinic Visit Workbook), and then proceed to Question #15.

Go to Question #15 on the next page.

Knee Surgery

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



15. Since your last telephone interview, did you have any surgery in your left knee?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know/Refused

V2SURGL

Go to Question #17.

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

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

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2ARTL

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

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2MENL

c. Ligament repair in your left knee?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2LIGL

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

☐ Yes

☐ No

☐ Don't know

V23KNRL

Examiner Note: Please complete the Event Notification Form and mark Left Total Knee Replacement; record that participant had left knee replacement on Page 23, Question H; and then go to Question #16e below.

e. Another kind of surgery in your left knee?

☐ 1 Yes

☐ 0 No

☐ 8 Don't know

V2SOTHL

f. i. Are any of the answers for Questions #16a-16e above marked "Yes"?

☐ Yes

☐ No

V23SUMYL

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

☐ Yes

☐ No

☐ Don't know

V2MIMPL

Examiner Note: Record that participant has metal implants in left knee on the OrthOne 1.0 T form (Page 32, Question #8 in the Second Follow-up Clinic Visit Workbook), and then proceed to Question #17.

Go to Question #17 on the next page.

MOST ID #	Acrostic
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Hip Pain

The next few questions are about your hip joints.

Right Hip

First I'll ask you about your right hip.

- 17.** 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.
(Examiner Note: **REQUIRED - Show Card #1.**)

☐ ¹ Yes
 ☐ ⁰ No
 ☐ ⁸ Don't know/Refused
 V2ANYR

- 17a.** 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
 V2HPN30R

Where is this pain, aching, or stiffness located?

(Examiner Note: **REQUIRED - Show Card #1. Please mark all that apply.**)

- 1=YES**
- V2GRINR** ☐ 1 Groin/inside leg near hip
 - V2OTLGR** ☐ 2 Outside of leg near hip
 - V2FRLGR** ☐ 3 Front of leg near hip
 - V2BUTTR** ☐ 4 Buttocks
 - V2LWBKR** ☐ 5 Lower back
 - V2PNDKR** ☐ Don't know

Examiner Note: Record that participant has right hip pain on the Knee and Hip Exam form (Page 23, Question C in the Second Follow-up Clinic Visit Workbook).

Hip Pain

MOST ID #	Acrostic
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Left Hip

Now I'll ask you about your left hip.

18. 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.

(Examiner Note: REQUIRED - Show Card #1.)

1 ☐ Yes

0 ☐ No

8 ☐ Don't know/Refused

V2ANYL

- 18a. 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

V2HPN30L

Where is this pain, aching, or stiffness located?

(Examiner Note: REQUIRED - Show Card #1. Please mark all that apply.)

V2GRINL ☐ 1 Groin/inside leg near hip

V2OTLGL ☐ 2 Outside of leg near hip

V2FRLGL ☐ 3 Front of leg near hip

V2BUTTL ☐ 4 Buttocks

V2LWBKL ☐ 5 Lower back

V2PNDKL ☐ Don't know

1=YES

Examiner Note: Record that participant has left hip pain on the Knee and Hip Exam form (Page 23, Question D in the Second Follow-up Clinic Visit Workbook).

MOST ID #	Acrostic
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Hip Surgery

19. Since your last telephone interview, did you have a right total hip replacement, where all or part of the joint was replaced?

☐ Yes



☐ No

☐ Don't know/Refused

Examiner Note: Please complete the Event Notification Form and mark **Right Hip Replacement**; record that participant had a right hip replacement on Page 23, Question E; and go on to Question #20.

20. Since your last telephone interview, did you have a left total hip replacement, where all or part of the joint was replaced?

☐ Yes



☐ No

☐ Don't know/Refused

Examiner Note: Please complete the Event Notification Form and mark **Left Hip Replacement**; record that participant had a left hip replacement on Page 23, Question F; and go on to Question #21.

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



Medication History

21. Since your first visit to the MOST clinic, have you taken a bisphosphonate medication to treat or prevent osteoporosis or to treat Paget's disease? This includes the following medications: alendronate (Fosamax), Risedronate (Actonel), etidronate (Didronel), ibandronate (Boniva), Pamidronate (Aredia), or tiludronate (Skelid).

(Examiner Note: Refer to Card #2 for pronunciation. Do Not Show Card to participants.)

V2BI

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

↓

Go to Question #22.

- 21a. For how many years did you take bisphosphonates?
If you are unsure, please make your best guess.

V2BIYR

years

**(Examiner Note:
Round up year at 6 months.
<6 months=0 years,
and 6-12 months=1 year;
if 10+ put 10 years)**

Medication History

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



Now think about the last 6 months.

22. During the past 6 months, have you had any injections in either of your knees for treatment of arthritis?

V2KINJ 1 Yes 0 No 8 Don't know/Refused

- 22a. During the past 6 months, have you had an injection of hyaluronic acid (Synvisc® or Hyalgan®) in either of your knees for treatment of your arthritis? These injections are given as a series of 3 to 5 weekly injections.

V2HYINJ 1 Yes 0 No 8 Don't know

- i. In which knee?

V2HYKN 1 Right knee 2 Left knee 3 Both knees 8 Don't know

- 22b. During the past 6 months, have you had an injection of steroids (cortisone, corticosteroids) in either of your knees for treatment of your arthritis?

V2STEROD 1 Yes 0 No 8 Don't know

- i. In which knee?

V2STKN 1 Right knee 2 Left knee 3 Both knees 8 Don't know

(Male participants only. Female participants: Skip to Question #24)

23. During the past 6 months, have you taken male hormone or testosterone, which is given by injection, patch, or rubbed on your skin?

V2TEST 1 Yes 0 No 8 Don't know/Refused

- 23a. When was the last time you had an injection, put on a patch, or rubbed this hormone on your skin? If you are unsure, please make your best guess.

(Examiner Note: Read response options.)

V2TSTM 1 Less than 1 month ago
2 1 to 2 months ago
3 3 to 6 months ago
8 Don't know

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"/>



Medication History

Female participants only. Male participants: Skip to Question #31.

Now think about the past year.

24. During the past year have you taken Tamoxifen (also called Novadex), Raloxifene (also called Evista), or Toremifene (also called Fareston) to treat or prevent breast or ovarian cancer?

V2ESTR 1 ☐ Yes 0 ☐ No 8 ☐ Don't know/Refused

- a. When was the last time you took this? If you are unsure, please make your best guess.
(Examiner Note: **REQUIRED: Read response options. Show Card #3.**)

V2ESTTM 1 ☐ Less than 1 month ago
 2 ☐ 1 to 2 months ago
 3 ☐ 3 to 6 months ago
 4 ☐ More than 6 months ago
 8 ☐ Don't know

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



Pregnancy / Menstrual History

25. Have you ever been pregnant?

V2PREGE ☒ 1 Yes ☐ 0 No ☐ 8 Don't know/Refused

25a. How many children did you give birth to?

V2NCHLD children

Note: if reported 6 or more children,
coded as value 6
☐ Don't know

26. Have you ever had an ovary removed?

V2OVREM ☒ 1 Yes ☐ 0 No ☐ 8 Don't know/Refused

26a. How many ovaries were removed?

V2OVNUM ☒ 1 One ☒ 2 Two (both) ☐ 8 Don't know

26b. At what age(s) did you have this done? If you are unsure, please make your best guess.
(Examiner Note: If ovaries removed at different times, record age when each surgery occurred.)

V2OVYO years old

☐ Don't know

V2OVAGE45

V2OVYO2 years old

☐ Don't know

27. Have you ever had a hysterectomy (surgery to remove your uterus or womb)?

V2HYS ☒ 1 Yes ☐ 0 No ☐ 8 Don't know/Refused

27a. How old were you when you had this surgery? If you are unsure, please make your best guess.

V2HYAGE years old

☐ Don't know

V2HYAGE45

Go to Page 15, Question #30 and
mark "Pregnancy test not required."

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"/>



Pregnancy Screen

28. This study includes x-rays and MRI scans, and if you are pregnant or trying to get pregnant, you are not eligible for x-rays or MRIs. Are you pregnant or trying to get pregnant?

☐ Yes

☐ No

☐ Don't know/Refused

Go to Procedure Checklist and mark, "Not eligible/Not applicable" for x-ray and MRIs. Go to Page 29, Question #2 and mark "Participant not eligible." Go to Page 32, Question #8 and mark, "No."

29. When was your last natural menstrual period? Do not include bleeding due to taking female hormone pills or patches.

(Examiner Note: Read response options.)

☐ Within the past 12 months

Examiner Note: Administer pregnancy test.

☐ 1 to 2 years ago

☐ 3 to 4 years ago

☐ 5 or more years ago

☐ Don't know

Examiner Note: If participant is between 52-55 years old, administer pregnancy test.

☐ Refused

Go to Procedure Checklist and mark, "Not eligible/Not applicable" for x-ray and MRIs. Go to Page 29, Question #2 and mark "Participant not eligible." Go to Page 32, Question #9 and mark, "No."

30. Did participant have a positive pregnancy test?

(Examiner Note: Do not ask the question. Please refer to Question 29 above to determine who requires a pregnancy test. If participant mentioned having had a tubal ligation, a pregnancy test is not required.)

☐ Yes (positive test)

☐ No (negative test)

☐ Pregnancy test not required

☐ Participant refused test

Go to Procedure Checklist and mark, "Not eligible/Not applicable" for x-ray and MRIs. Go to Page 29, Question #2 and mark "Participant not eligible." Go to Page 32, Question #9 and mark, "No."

MOST ID #	Acrostic
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Medication Use Interview

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

31a. Vitamin E

V2VITE ¹ ☐ Yes ⁰ ☐ No ⁸ ☐ Don't know/Refused

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

- ¹ ☐ Less than 100 IU **V2VITED**
² ☐ 100 to 250 IU
³ ☐ 300 to 500 IU
⁴ ☐ 600 IU or more
⁸ ☐ Don't know

31b. Vitamin C

V2VITC ¹ ☐ Yes ⁰ ☐ No ⁸ ☐ Don't know/Refused

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

- ¹ ☐ Less than 400 mg **V2VITCD**
² ☐ 400 to 700 mg
³ ☐ 750 to 1,250 mg
⁴ ☐ 1,300 mg or more
⁸ ☐ Don't know

Blood Pressure

MOST ID #	Acrostic	Staff ID#
<div></div> <div></div> <div></div> <div></div> <div></div> <div></div>	<div></div> <div></div> <div></div> <div></div>	<div></div> <div></div> <div></div>



1. What cuff size was used?

☐ Small

☐ Regular

☐ Large

☐ Thigh **V2CUFF**

2. What arm was used to take the blood pressure?

(Examiner Note: Use the right arm unless there are contraindications.)

☐ Right

☐ Left

V2ARM

Pulse Obliteration Level: Complete only if using a sphgmomanometer.

3. Palpated Systolic

V2LEVEL

 mm Hg

+

30

 *

*** Add 30 to Palpated Systolic measurements to obtain Maximal Inflation Level.**

Maximal Inflation Level **
(MIL)

 mm Hg

V2MIL

**** If MIL is \geq 300 mm Hg, repeat the MIL. If MIL is still \geq 300 mm Hg, terminate blood pressure measurement.**

4. Was blood pressure measurement terminated because MIL is \geq 300 mm Hg after second reading?

☐ Yes

☐ No **V2STOP**

5.

Systolic mm Hg

V2SBP

Diastolic mm Hg

V2DBP

MOST ID #	Acrostic	Staff ID#
<div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div><div></div></div>	<div><div></div><div></div><div></div></div>



Weight

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

•

kg

V2WGHT

V2WT

V2BMI

20-Meter Walk

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



1. Directions:

"Now we want to measure your usual walking speed. You will start behind this line. When you have passed the orange cone, I want you to stop."

(Examiner Note: Demonstrate how to walk past cone and stop.)

"Now when I say 'Go,' I want you to walk at your usual walking pace. Any questions?"

"Ready, Go."

Begin timing and counting steps with the first footfall over the starting line and stop with the first footfall over the finish line.)

	V2STEP1	V2WALKT1	
Trial 1	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Steps	Second	Hundredths/Sec
V2WALK1	<input type="radio"/> Done	<input type="radio"/> Participant refused	<div style="border: 1px solid black; padding: 10px; text-align: center;"> Stop test. Go to next exam. </div>
	<input type="radio"/> Not attempted, unable	<input type="radio"/> Attempted, unable to complete	

2. Directions:

Reset the stopwatch and have the participant repeat the 20-meter walk by walking back in the other direction.

"OK, fine. Now turn around and when I say 'Go,' walk back the other way at your usual walking pace. Ready, Go."

	V2STEP2	V2WALKT2	
Trial 2	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Steps	Second	Hundredths/Sec
V2WALK2	<input type="radio"/> Done	<input type="radio"/> Participant refused	<div style="border: 1px solid black; padding: 10px; text-align: center;"> Stop test. Go to next exam. </div>
	<input type="radio"/> Not attempted, unable	<input type="radio"/> Attempted, unable to complete	

V2_STEP

V2_WALKT

3. Was the participant using a walking aid, such as a cane? ☐ Yes ☐ No

V2AID

Chair Stands

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"/>



Single Chair Stand

Directions:

"This is a test of strength in your legs in which you stand up without using your arms."

(Examiner Note: Demonstrate and say:) "Fold your arms across your chest, like this, and stand when I say 'Go,' keeping your arms in this position. OK?"

"Ready, Go!"

1. Single Chair Stand

1 ☐ Stands without using arms

4 ☐ Rises using arms

7 ☐ Participant refused

2 ☐ Not attempted, unable

3 ☐ Attempted, unable to stand

Go to Repeated Chair Stands
on the next page.

Stop test.
Go to next exam.

V2CHAIR

Repeated Chair Stands

MOST ID #	Acrostic
<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>	<div></div> <div></div> <div></div> <div></div> <div></div>



Repeated Chair Stands

Directions: (**Examiner Note: Demonstrate and say:**)

"This time, I want you to stand up five times as quickly as you can keeping your arms folded across your chest. When you stand up, come to a full standing position each time, and when you sit down, sit all the way down each time.

I will demonstrate two chair stands to show you how it is done."

(Examiner Note: Rise two times as quickly as you can, counting as you stand up each time.)

"When I say 'Go' stand five times in a row, as quickly as you can, without stopping. Stand up all the way, and sit all the way down each time."

"Ready, Go!"

(Examiner Note: Start timing as soon as participant begins to stand. Count aloud: "1, 2, 3, 4, 5" as the participant stands up each time.)

2.

1	V2TR1		V2CTIME1	
<input type="radio"/>	Completes 5 stands without using arms	→	<div></div> <div></div> . <div></div> <div></div>	Seconds (Time on stopwatch)
4	<input type="radio"/> Rises using arms	→	<div>Stop test. Go to next exam.</div>	
7	<input type="radio"/> Participant refused	→		
2	<input type="radio"/> Not attempted, unable	→		
3	<input type="radio"/> Attempted, unable to complete	→	<div></div>	V2NUM1 Number completed without using arms

Knee and Hip Examinations

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



BOX 1. SELF-REPORTED KNEE and HIP PAIN AND KNEE and HIP REPLACEMENT (Examiner Note: Refer to Second Follow-up Clinic Visit Workbook. Please mark ALL that apply.)

- Did participant answer "Yes" to Question 2a. regarding right knee pain? (Page 2)
- A. Right knee pain** ☐ Yes ☐ No ☐ Don't know/Refused
- Did participant answer "Yes" to Question 4a. regarding left knee pain? (Page 3)
- B. Left knee pain** ☐ Yes ☐ No ☐ Don't know/Refused
- Did participant answer "Yes" to Question 17a. regarding right hip pain? (Page 8)
- C. Right hip pain** ☐ Yes ☐ No ☐ Don't know/Refused
- Did participant answer "Yes" to Question 18a. regarding left hip pain? (Page 9)
- D. Left hip pain** ☐ Yes ☐ No ☐ Don't know/Refused
- Was right hip replaced? Refer to page 10, Question #19 and Data from Prior Visits Report.
- E. Right hip replaced** ☐ Yes ☐ No ☐ Don't know/Refused
- ↓
- Mark "Yes" to Questions # 1, 9, & 19 regarding hip replacement.
- Was left hip replaced? Refer to Page 10, Question #20 and Data from Prior Visits Report.
- F. Left hip replaced** ☐ Yes ☐ No ☐ Don't know/Refused
- ↓
- Mark "Yes" to Questions # 16, 17, & 20 regarding hip replacement.
- Was right knee replaced? Refer to Page 6, Question #14d. and Data from Prior Visits Report.
- G. Right knee replaced** ☐ Yes ☐ No ☐ Don't know/Refused
- ↓
- Mark "Yes" to Question # 3 and tell examiner to not do right knee exams.
- Was left knee replaced? Refer to Page 7, Question #16d. and Data from Prior Visits Report.
- H. Left knee replaced** ☐ Yes ☐ No ☐ Don't know/Refused
- ↓
- Mark "Yes" to Question # 10 and tell examiner to not do left knee exams.

EXAM ELIGIBILITY

- I. Is either item A or B (knee pain) marked "Yes"?**
- ☐ Yes ☐ No

↓

Perform **hip and knee** exams

- Is either item C or D (hip pain) marked "Yes"?
- ☐ Yes ☐ No

↓

STOP. Go to next exam.

↓

Perform **ONLY** hip exams (asterisked[*] unless contraindicated).
(Exams# *1, *9, *16, *17, *19, *20)

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="text"/>



Knee and Hip Examinations

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

Exam	"Is this tender or painful?"
* 1. Trochanteric bursitis Has the participant had a <u>right</u> hip replacement? <i>(Examiner Note: Refer to Page 23, Question E.)</i>	<input type="radio"/> No → 1 Yes 0 No 8 Not done 7 Refused V2PN1R <input type="radio"/> Yes <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> Do NOT perform <u>right</u> trochanteric bursitis exam. </div>
2. Iliotibial band →	<input type="radio"/> Yes 0 No 8 Not done 7 Refused V2PN2R

- 3. Has participant had right knee surgery where all or part of the joint was replaced?**
(Examiner Note: Refer to Page 23, Question G.)

☐ Yes ☐ No
 ↓

Go to page 25, Question #9.

*Refer to Page 23, Question I to see if participant should ONLY have hip exams.

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"/> <input type="text"/>



Knee and Hip Examinations

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

Exam	"Is this tender or painful?"
4. Anserine bursa V2PN3R →	1 Yes 0 No 8 Not done 7 Refused
5. Medial tibiofemoral joint line V2PN4R →	1 Yes 0 No 8 Not done 7 Refused
6. Lateral tibiofemoral joint line V2PN5R →	1 Yes 0 No 8 Not done 7 Refused
7. Patellar tenderness V2PN6R →	1 Yes 0 No 8 Not done 7 Refused
8. Medial knee fat pad tenderness V2PN7R →	1 Yes 0 No 8 Not done 7 Refused
<p>* 9. Hip internal rotation <u>pain</u> Has the participant had a <u>right</u> hip replacement? (Examiner Note: Refer to Page 23, Question E.)</p> <p> <input type="radio"/> No → "Is this tender or painful in your hip?" <input type="radio"/> Yes → Do NOT perform <u>right</u> hip pain exam. </p> <p>1=YES</p> <p> <input type="radio"/> Yes 0 No 8 Not done 7 Refused V2PN8R </p> <p>Where does it hurt? (Show Card #5. Mark <u>all</u> that apply.)</p> <p> <input type="radio"/> 1 Groin/inside leg near hip V2IRP1R <input type="radio"/> 2 Outside of leg near hip V2IRP2R <input type="radio"/> 3 Front of leg near hip V2IRP3R <input type="radio"/> 4 Buttocks V2IRP4R <input type="radio"/> 5 Lower back V2IRP5R <input type="radio"/> Don't know V2IRP6R </p>	
<p>10. Has participant had <u>left</u> knee surgery where all or part of the joint was replaced? (Examiner Note: Refer to Page 23, Question H.)</p> <p> <input type="radio"/> Yes → Go to Page 26, Question #16. <input type="radio"/> No </p>	

*Refer to Page 23, Question I to see if participant should ONLY have hip exams.

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"/>



Knee and Hip Examinations

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

Exam	"Is this tender or painful?"
11. Anserine bursa V2PN9L	<input checked="checked" type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused
12. Medial tibiofemoral joint line V2PN10L	<input checked="checked" type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused
13. Lateral tibiofemoral joint line V2PN11L	<input checked="checked" type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused
14. Patellar tenderness V2PN12L	<input checked="checked" type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused
15. Medial knee fat pad tenderness V2PN13L	<input checked="checked" type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused
* 16. Hip internal rotation <u>pain</u> Has the participant had a <u>left</u> hip replacement? <i>(Examiner Note: Refer to Page 23, Question F.)</i>	<div style="display: flex; align-items: center;"> <div style="margin-right: 20px;"> <input type="radio"/> No <input type="radio"/> Yes <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Do NOT perform <u>left</u> hip pain exam. </div> </div> <div> <input checked="checked" type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done <input type="radio"/> 7 Refused V2PN14L <div style="border: 1px solid black; padding: 10px; margin-top: 10px;"> Where does it hurt? (Show Card #5, Mark <u>all</u> that apply.) <input type="radio"/> 1 Groin/inside leg near hip V2IRP1L <input type="radio"/> 2 Outside of leg near hip V2IRP2L <input type="radio"/> 3 Front of leg near hip V2IRP3L <input type="radio"/> 4 Buttocks V2IRP4L <input type="radio"/> 5 Lower back V2IRP5L <input type="radio"/> Don't know V2IRP6L </div> </div> </div>

*Refer to Page 23, Question I to see if participant should ONLY have hip exams.

Knee and Hip Examinations

MOST ID #	Acroscopic
<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>	<div></div> <div></div> <div></div> <div></div> <div></div>



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 <u>left</u> hip replacement? (Examiner Note: Refer to Page 23, Question F.)</p> <p> <input type="radio"/> No → 1 Yes 0 No 8 Not done 7 Refused V2PN15L </p> <p><input type="radio"/> Yes</p> <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> Do NOT perform <u>left</u> trochanteric bursitis exam. </div>	
<p>18. Iliotibial band</p> <p>→ 1 Yes 0 No 8 Not done 7 Refused V2PN16L </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? (Examiner Note: Refer to Page 23, Question E.)</p> <p> <input type="radio"/> No → V2LOMR <div style="border: 1px solid black; display: inline-block; width: 40px; height: 20px;"></div> degrees <input type="radio"/> Not done <input type="radio"/> Refused </p> <p><input type="radio"/> Yes</p> <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> Do NOT perform <u>right</u> hip exam. </div>	
<p>*20. Left hip internal rotation Has the participant had a <u>left</u> hip replacement? (Examiner Note: Refer to Page 23, Question F.)</p> <p> <input type="radio"/> No → V2LOML <div style="border: 1px solid black; display: inline-block; width: 40px; height: 20px;"></div> degrees <input type="radio"/> Not done <input type="radio"/> Refused </p> <p><input type="radio"/> Yes</p> <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> Do NOT perform <u>left</u> hip exam. </div>	

*Refer to Page 23, Question I to see if participant should ONLY have hip exams.

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"/> <input type="text"/> <input type="text"/> <input type="text"/>



Knee and Hip Examinations

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 **V2EX19**



Exam		"Is this tender or painful?"
a. Right elbow tenderpoint	V2PN19A	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused
b. Left elbow tenderpoint	V2PN19B	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Not done <input type="radio"/> Refused
c. Right trapezius tenderpoint	V2PN19C	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Not done <input type="radio"/> Refused
d. Left trapezius tenderpoint	V2PN19D	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Not done <input type="radio"/> Refused

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

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? ☒ Yes ☐ No **V2XRAY**

- ☐ Participant not eligible (e.g., pregnant, bilateral knee replacement)
☐ Participant refused x-rays at clinic visit
☐ Equipment failure **V2XRAYN**
☐ Participant did not show up for appointment/would not reschedule
☐ Other (**Please specify:** _____)

3. What is the MOST staff ID# for the X-ray technician? **V2XSID**

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

- a. PA semiflexed view of right and left knee?

V2PA

☒ Yes

- i. mAs setting **V2PAMAS**
 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.**
☐ 5° ☐ 10° ☐ 15° **1=YES**

☐ No

Comments: _____

- b. Lateral view of right knee?

V2LR

☒ Yes

- i. mAs setting **V2LRMAS**

☐ No

Comments: _____

- c. Lateral view of left knee?

V2LL

☒ Yes

- i. mAs setting **V2LLMAS**

☐ No

Comments: _____

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"/>
		Month Day Year	



☐ First knee MRI ☐ Repeat knee MRI

OrthOne 1.0 T 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 32, Question #9, and mark "No."

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

(Examiner Note: Do not re-weigh participant. Check weight measurement on page 20 in the Second Follow-up Clinic Visit Workbook.)

☐ Yes

☐ No

Not eligible for MRI. Go to Page 32, Question #9, and mark "No."

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 31, 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 33, Question #11a and #11b, and mark "Participant scheduled for a later date." Schedule MRI for 2 months after surgery date. Complete and scan Pages 31, 32, 33, and 34 when participant returns for MRI.

Go to Page 31, Question #4.

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"/>



OrthOne 1.0 T Knee MRI

☐ 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 dental implant or dentures, magnetic eye implant, or other magnetic device	<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 → ☐ 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	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused

5a. Since your last visit to the MOST clinic on [month/year], have you had an injury in which metal fragments entered your eye and you had to seek medical attention? (**Examiner Note: Refer to Data from Prior Visits Report for month/year of last MRI scan.**) ☐ 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="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"/>



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, and mark "No."

7. Is there any other reason why this participant would not be eligible for an MRI? ☐ Yes ☐ No

☐ Yes

☐ No

What is the reason?

Not eligible for MRI.
Go to Question #9, and mark "No."

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, Page 6, Question #14d, and Page 7, Question #16d in Second Follow-up Clinic Visit Workbook.**)

☐ Yes

☐ No

Which knee was replaced or has metal implants?

☐ Right

☐ Left

☐ Both knees

Do not scan right knee.

Do not scan left knee.

Not eligible for MRI.
Go to Question #9 and mark "No."

9. Is the participant eligible for an OrthOne 1.0 T knee MRI scan? ☐ Yes ☐ No

☐ Yes

☐ No

Tech. signature: _____

Go to Page 33, Question #11.

10. Which knee(s) is being scanned?
(**Examiner Note: To determine which knee(s) to scan: Scan both knees unless contraindicated - refer to Question #8 above.**)

☐ Right knee

☐ Left knee

☐ Both knees

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	



OrthOne 1.0 T Knee MRI

☐ First knee MRI ☐ Repeat knee MRI

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

V2ONIR

☒ Yes

☐ No →

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

- ☐ Participant not eligible
- ☐ Participant had right total knee replacement
- ☐ Participant's leg did not fit in MRI scanner
- ☐ Participant refused
- ☐ Participant scheduled for a later date
- ☐ Other (**Please specify:** _____)

V2NOR

b. Was an MRI obtained of the left knee?

V2ONIL

☒ Yes

☐ No →

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

- ☐ Participant not eligible
- ☐ Participant had left total knee replacement
- ☐ Participant's leg did not fit in MRI scanner
- ☐ Participant refused
- ☐ Participant scheduled for a later date
- ☐ Other (**Please specify:** _____)

V2NOL

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



☐ First knee MRI ☐ Repeat knee MRI

OrthOne 1.0 T Knee MRI

MRI Technologist ID#
<input type="text"/>

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 **(Examiner Note: Refer to Data From Prior Visits Report to see if 3 Point Dixon should be obtained.)**

☐ 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 **(Examiner Note: Refer to Data From Prior Visits Report to see if 3 Point Dixon should be obtained.)**

☐ 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	



☐ First knee MRI ☐ Repeat knee MRI

Eligibility for 1.5 T Knee MRI

1. Has the participant been selected for any 1.5 T MRI study?
(Examiner Note: Refer to Data from Prior Visits Report)

☐ Yes

☐ No →

Not eligible for 1.5 T MRI. Go to Page 35a, Question #1.

2. Is the participant currently MRI eligible?
(Examiner Note: Refer to Page 32, Question #9.)

☐ Yes

☐ No →

Not eligible for 1.5 T MRI. Go to Page 35a, Question #1.

3. Which study(ies) has the participant been selected for?
(Examiner Note: Refer to Data from Prior Visits Report. Mark all that apply.)

☐ 1.5 T MRI Laxity Study

☐ MRI Validation Study

☐ Gadolinium MRI Study

Participants selected for validation study only. All others, go to Question #5.

4. Were all three 1.0 T knee MRI sequences (axial, coronal STIR and sagittal) obtained, and did the scans pass MRI technologist quality assurance? (Examiner Note: Refer to Page 34, Question #12.)

☐ Yes →

Eligible for validation study. Go to Question #5.

☐ No →

Not eligible for validation study. Go to Question #5.

5. Summary of exams scheduled
(Examiner Note: Refer to Questions #3 and 4 above. Answer for all exams.)

Participant is eligible, has given consent, and the exam is scheduled?			
a. 1.5 T MRI Laxity Study	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused → Reason: <input type="radio"/> No time/ too busy <input type="radio"/> Other: _____
b. MRI Validation Study	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused → Reason: <input type="radio"/> No time/ too busy <input type="radio"/> Other: _____
c. Gadolinium MRI Study	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Refused → Reason: <input type="radio"/> Unwilling to receive injection <input type="radio"/> No time/ too busy <input type="radio"/> Other: _____

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



☐ First sample collection ☐ Repeat sample collection

Eligibility for Biospecimen Collection

1. Is participant in the biospecimen collection cohort for this visit?

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

☐ Yes

☐ No

Male participants: Go to next exam.

Female participants: Is a pregnancy test required for x-ray and MRI safety?

☐ Yes

☐ No

Go to Page 36, Question #1 and obtain a urine specimen.

(**Examiner Note: Do not collect blood.**)

Go to next exam.

2. Has participant had a total knee replacement in either knee?

(**Examiner Note: Refer to Page 6, Question #14d, Page 7, Question #16d, and Data From Prior Visits Report.**)

☐ Yes

☐ No

Go to Question #3 and mark "Yes."

Not eligible for biospecimen collection.
Go to Question #3 and mark "No."

3. Is participant eligible for biospecimen collection?

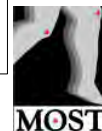
☐ Yes

☐ No

Go to next exam.

Go to page 36, Question #1.

MOST ID #	Acrostic	Date of Urine Collection	Staff ID#
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>
		Month / Day / Year	



Urine Collection

☐ First sample collection ☐ Repeat sample collection

1. Is urine collection for the biospecimen cohort or for pregnancy test only?
(Examiner note: Refer to Page 35a, Question #1.)

☐ Biospecimen cohort ☐ Pregnancy test only

2. Was a urine specimen obtained?

☐ Yes

☐ No

Go to Question #5 and explain.

Biospecimen cohort: Go to Question #2a.

Pregnancy test only: Go to Question #4.

- a. Which void(s) was collected?

(Examiner note: Mark all that apply; if one void is insufficient volume, it is permissible to combine two specimens, as long as neither is the first morning void.)

☐ First ☐ Second ☐ Third ☐ Fourth or later

Try to obtain a second-void specimen before noon and before the participant leaves the clinic. Do not aliquot first-void specimen unless later void not obtained.

- b. What time was the urine specimen collected?

(Examiner note: If two specimens are combined, please write the later of the two times.)

<input type="text"/>	:	<input type="text"/>
Hours		Minutes

☐ am ☐ pm

- c. **Ask participant:** What is the date and time you last ate or drank anything except water?

i. Date:

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

ii. Time:

<input type="text"/>	:	<input type="text"/>
Hours		Minutes

☐ am ☐ pm

iii. How many hours has participant fasted?

<input type="text"/>	Hours
----------------------	-------

- d. Place of urine collection: ☐ Home ☐ Clinic

Bar Code Label

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------

Enter ID from Bar Code label:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------

Ask participant:

3. What time did you get up for the day today?

<input type="text"/>	:	<input type="text"/>
Hours		Minutes

☐ am ☐ pm

Female participants only.

Male participants: Skip to Question #5.

4. Is a pregnancy test required?

(Examiner Note: Please refer to Page 15, Question #29 to see if participant requires pregnancy test.)

☐ Yes

☐ No

Collect urine and administer pregnancy test.

☐ Positive ☐ Negative ☐ Participant refused test

Participant NOT ELIGIBLE for x-rays or MRI. Go to Page 15, Question #30 and mark appropriate bubble. Then go to Page 37, Question #1 if participant is in the specimen collection cohort.

5. Comments on urine collection:

<input type="text"/>
<input type="text"/>
<input type="text"/>

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

Phlebotomy

☐ First sample collection ☐ Repeat sample collection



Now I'm going to ask you two questions to see whether it is safe to draw your blood.

1. Have you ever had an arm graft shunt or port for kidney dialysis?

☐ Yes ☐ No ☐ Don't know/Refused

Go to Question #3 and mark "Neither."

Which side?

☐ Right

☐ Left

☐ Both

Draw blood on left side.

Draw blood on right side.

Do NOT draw blood on either side. Go to Question #3 and mark "Neither."

2. Have you ever had a radical mastectomy or other surgery where lymph nodes were removed from your armpit?

☐ Yes ☐ No ☐ Don't know/Refused

Go to Question #3 and mark "Neither."

Which side?

☐ Right

☐ Left

☐ Both

Draw blood on left side.

Draw blood on right side.

Do NOT draw blood on either side. Go to Question #3 and mark "Neither."

3. Which arm(s) can safely be used for phlebotomy?
(Examiner Note: Refer to Questions #1 and #2.)

☐ Right ☐ Left ☐ Either ☐ Neither

Do NOT draw blood. Go to Procedure Checklist and mark appropriate bubble.

4. Have you had an illness in the past week requiring antibiotics, hospitalization, or steroids?

☐ Yes ☐ No ☐ Don't know/Refused

5. Do you bleed or bruise easily?

☐ Yes ☐ No ☐ Don't know/Refused

6. Have you ever been told you have a disorder related to blood clotting or coagulation?

☐ Yes ☐ No ☐ Don't know/Refused

7. Have you ever experienced fainting spells while having blood drawn?

☐ Yes ☐ No ☐ Don't know/Refused

8. What is the date and time you last ate or drank anything except water?

(Examiner Note: Do not repeat question if already asked for urine collection.)

a. Date:

/ /

Month Day

b. Time:

: ☐ am
Hours Minutes ☐ pm

c. How many hours has participant fasted?

Hours

9. Was any blood drawn?

(Examiner Note: Proceed with the blood draw even if participant has not fasted.)

☐ Yes ☐ No

Please describe why not: _____

Were tubes filled to specified capacity?

(Note: wrap all tubes in foil or place in sheath.)

Tube	Volume	Filled to Capacity
1. EDTA	3 - 5 mL	<input type="radio"/> Yes <input type="radio"/> No
2. Serum	7 - 10 mL	<input type="radio"/> Yes <input type="radio"/> No

Time of blood draw:

: ☐ am
Hours Minutes ☐ pm

10. Comments on phlebotomy:

MOST ID #	Acroscopic	Staff ID#
<div style="border: 1px solid black; width: 100px; height: 30px;"></div>	<div style="border: 1px solid black; width: 100px; height: 30px;"></div>	<div style="border: 1px solid black; width: 100px; height: 30px;"></div>



Laboratory Processing

☐ First sample collection ☐ Repeat sample collection

Time at start of EDTA plasma processing:

☐ am
☐ pm

Hours Minutes

Collection Tubes	Cryo #	Vol.	Cap	Condition of cryovial (mark only <u>one</u>)				
#1 EDTA plasma tube								
-plasma	01	0.5	V	<input type="radio"/> OK	<input type="radio"/> H	<input type="radio"/> P	<input type="radio"/> B	<input type="radio"/> not filled
-plasma	02	0.5	V	<input type="radio"/> OK	<input type="radio"/> H	<input type="radio"/> P	<input type="radio"/> B	<input type="radio"/> not filled
-plasma	03	0.5	V	<input type="radio"/> OK	<input type="radio"/> H	<input type="radio"/> P	<input type="radio"/> B	<input type="radio"/> not filled

Ending time of EDTA plasma aliquoting:

☐ am
☐ pm

Hours Minutes

Bar Code Label

Enter ID from Bar Code label:

Time at start of serum processing:

☐ am
☐ pm

Hours Minutes

Collection Tubes	Cryo #	Vol.	Cap	Condition of cryovial (mark only <u>one</u>)				
#2 Serum tube								
-serum	04	0.5	R	<input type="radio"/> OK	<input type="radio"/> H	<input type="radio"/> P	<input type="radio"/> B	<input type="radio"/> not filled
-serum	05	0.5	R	<input type="radio"/> OK	<input type="radio"/> H	<input type="radio"/> P	<input type="radio"/> B	<input type="radio"/> not filled
-serum	06	0.5	R	<input type="radio"/> OK	<input type="radio"/> H	<input type="radio"/> P	<input type="radio"/> B	<input type="radio"/> not filled
-serum	07	0.5	R	<input type="radio"/> OK	<input type="radio"/> H	<input type="radio"/> P	<input type="radio"/> B	<input type="radio"/> not filled
-serum	08	0.5	R	<input type="radio"/> OK	<input type="radio"/> H	<input type="radio"/> P	<input type="radio"/> B	<input type="radio"/> not filled
-serum	09	0.5	R	<input type="radio"/> OK	<input type="radio"/> H	<input type="radio"/> P	<input type="radio"/> B	<input type="radio"/> not filled
-serum	10	0.5	R	<input type="radio"/> OK	<input type="radio"/> H	<input type="radio"/> P	<input type="radio"/> B	<input type="radio"/> not filled

Ending time of serum aliquoting:

☐ am
☐ pm

Hours Minutes

Urine						
-urine	11	0.5	C	<input type="radio"/> OK	<input type="radio"/> P	<input type="radio"/> not filled
-urine	12	0.5	C	<input type="radio"/> OK	<input type="radio"/> P	<input type="radio"/> not filled
-urine	13	0.5	C	<input type="radio"/> OK	<input type="radio"/> P	<input type="radio"/> not filled
-urine	14	0.5	C	<input type="radio"/> OK	<input type="radio"/> P	<input type="radio"/> not filled

H=Hemolyzed P=Partial B=Both V=Violet R=Red C=Clear