



MOST PUBLIC DATA RELEASE
ANNOTATED DATA COLLECTION FORMS
BASELINE 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**

Baseline Telephone Screening Interview



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"/> MOSTID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ACROSTIC	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> VO_TIDATE	<input type="radio"/> SITE 1 <input type="radio"/> SITE 2 SITE

Thank you for your interest in the **MOST** study.

MOST is short for Multicenter Osteoarthritis Study. This is a university research study that will help us learn how physical activities, weight, and diet affect knee pain and knee arthritis. Information gathered in this study may help us to better understand how to prevent and treat arthritis. You don't need to have arthritis or joint pain to participate. This study is open to men and women between the ages of 50 and 79. This study will not involve taking any medications or changing your eating or exercise habits. **MOST** will last 3 years and will require two or three clinic visits in [Iowa City] [Birmingham].

How did you hear about the **MOST** study? (*Interviewer Note: Mark all that apply.*)

- | | |
|--|--|
| TSHEAR1 <input type="radio"/> Brochure | TSHEAR7 <input type="radio"/> Radio advertisement |
| TSHEAR2 <input type="radio"/> Doctor | TSHEAR8 <input type="radio"/> Television |
| TSHEAR3 <input type="radio"/> Flyer | TSHEAR9 <input type="radio"/> Other (<i>Please specify:</i> _____) |
| TSHEAR4 <input type="radio"/> Friend/family | TSHEAR10 <input type="radio"/> Don't know/Don't remember |
| TSHEAR5 <input type="radio"/> Mail | TSHEAR11 <input type="radio"/> Refused |
| TSHEAR6 <input type="radio"/> Newspaper | |

Telephone Screening Interview

Screening 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"/>



Questions 1 - 6 on this page were for clinic use only and were not submitted to the SF Coordinating Center as collected data.

Telephone Screening Interview

Screening 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"/>



7. How old are you? years **AGE**

AGECAT

Is the participant at least 50 and not more than 79 years old? **TSA5079**

Yes

No



NOT ELIGIBLE.
Complete Box B.

8. Confirm gender, male or female **1** Male **0** Female **SEX**

9. Do you consider yourself to be Hispanic or Latino? **ETHNICITY ***

Yes No Don't know/Refused

10. What is your racial background? *(Interviewer Note: Mark one response option.)* **RACE ***

White or Caucasian More than one race *(Please specify: _____)*
 Black or African American _____)
 Asian Other *(Please specify: _____)*
 American Indian or Alaskan Native Don't know/Refused
 Hawaiian or Other Pacific Islander

* Enrolled participants were asked the same questions again on the Self-Administered Questionnaire - Home, page 1. The variables ETHNICITY and RACE are derived from that questionnaire.

Telephone Screening Interview

Screening 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"/>



11. What is your current weight? (best guess) **TSWT** lbs. Don't know/Refused **TSWGTKD**

(Interviewer Note: See table below to determine if the participant is potentially eligible and fill bubble if they are.)

- Female, ages 50 to 59: Equal to or greater than 154 lbs *
- Female, ages 60 to 69: Equal to or greater than 151 lbs *
- Female, ages 70 to 79: Equal to or greater than 148 lbs *
- Male, ages 50 to 59: Equal to or greater than 194 lbs *
- Male, ages 60 to 69: Equal to or greater than 187 lbs *
- Male, ages 70 to 79: Equal to or greater than 182 lbs *

TSCHECK

12. During the past 30 days, have you had any pain, aching or stiffness in or around either knee?

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

Yes →
 No →
 Don't know/Refused →

Go to Question #13.

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

1* Yes **0** No **8** Don't know **TSKNPNR**

12b. During the past 30 days, have you had pain, aching or stiffness in or around your left knee on most days?

1* Yes **0** No **8** Don't know **TSKNPNL**

13. Have you ever injured either of your knees so badly that it was difficult for you to walk for at least one week?

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

14. Have you ever had knee surgery?

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

Box A

Are one or more potentially eligible items marked? (These items have asterisks (). Participant is potentially eligible if one or more asterisked items are marked above.)*

TSBOXA

Yes No

Continue interview.

NOT ELIGIBLE.
 Complete Box B.

Telephone Screening Interview

Screening 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"/>



15. Have you ever had knee replacement surgery, where all or part of the joint was replaced?

TSKNR

- Yes No Don't know/Refused

15a. Which knee was replaced?

- Right knee only Left knee only Both knees

NOT ELIGIBLE.
Complete Box B.

15b. Are you considering having knee replacement surgery in your other knee in the next 12 months?

- Yes No Don't know

NOT ELIGIBLE.
Complete Box B.

Go to Question #17.

16. Are you considering having knee replacement surgery in the next 12 months?

TSKNRC

- Yes No Don't know/Refused

16a. Which knee are you considering for knee replacement surgery?

- Right knee only Left knee only Both knees

NOT ELIGIBLE.
Complete Box B.

17. In the past three years, have you been treated for cancer or been told by a doctor that you had cancer or a malignant tumor?

VOCANCR

- Yes No Don't know Refused

Go to Question #17a.

Go to Question #18.

Refer to Recruitment Coordinator.
Go to Question #18.

NOT ELIGIBLE.
Complete Box B.

Screening ID #	Acrostic



Telephone Screening Interview

17a. Please tell me what type of cancer you had.
(Interviewer Note: Don't read list; Mark all that apply.)

- Acute Leukemia → **NOT ELIGIBLE.**
Complete Box B.
- Brain → **NOT ELIGIBLE.**
Complete Box B.
- Breast → Go to Question #17b
- Cervical → Go to Question #17b
- Chronic Leukemia → **NOT ELIGIBLE.**
Complete Box B.
- Colon → Go to Question #17b
- Esophagus → **NOT ELIGIBLE.**
Complete Box B.
- Liver → **NOT ELIGIBLE.**
Complete Box B.
- Lung → **NOT ELIGIBLE.**
Complete Box B.
- Lymphoma → **NOT ELIGIBLE.**
Complete Box B.
- Melanoma → **NOT ELIGIBLE.**
Complete Box B.
- Multiple Myeloma → **NOT ELIGIBLE.**
Complete Box B.
- Pancreas → **NOT ELIGIBLE.**
Complete Box B.
- Prostate → Go to Question #17b
- Rectal → Go to Question #17b
- Skin
 - Melanoma → **NOT ELIGIBLE.**
Complete Box B.
 - Nonmelanoma → Go to Question #18
- Stomach → **NOT ELIGIBLE.**
Complete Box B.
- Uterine → Go to Question #17b
- Other (*Please specify:* _____) → Go to Question #17b.

17b. Did you receive radiation treatment and/or chemotherapy for cancer?

(Interviewer Note: Tamoxifen for breast cancer is not chemotherapy)

- Yes → **NOT ELIGIBLE.**
Complete Box B.
- No
- Don't know/Refused → **NOT ELIGIBLE.**
Complete Box B.

17c. Was cancer removed by surgery?

- Yes or "Watchful Waiting" for prostate cancer
- No → **NOT ELIGIBLE.**
Complete Box B.
(Exception: "Watchful Waiting" for prostate cancer.)
- Don't know/Refused → **NOT ELIGIBLE.**
Complete Box B.

Telephone Screening Interview

Screening 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"/>



18. Are you able to walk by yourself, without the help of another person and without a walker?

TSWLK

Yes

No

Don't know/Refused

NOT ELIGIBLE.
Complete Box B.

19. Do you have problems with your kidneys that require you to have hemodialysis or peritoneal dialysis?

TSKIDNY

Yes

No

Don't know/Refused

NOT ELIGIBLE.
Complete Box B.

NOT ELIGIBLE.
Complete Box B.

20. Do you have any other serious health problems that would make it very difficult for you to participate in a research study that will last at least 3 years?

TSKHLTH

Yes

No

Don't know

Refused

What is your health problem?

Refer to Recruitment Coordinator.
Go to Question #21.

Refer to Recruitment Coordinator.
Go to Question #21.

NOT ELIGIBLE.
Complete Box B.

21. Did a doctor ever tell you that you have any of the following kinds of arthritis?

TSAS

Ankylosing Spondylitis?

Yes

No

Don't know

NOT ELIGIBLE.
Complete Box B.

TSPA

Psoriatic Arthritis?

Yes

No

Don't know

NOT ELIGIBLE.
Complete Box B.

TSRS

Reiters Syndrome?

Yes

No

Don't know

NOT ELIGIBLE.
Complete Box B.

Telephone Screening Interview

Screening 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"/>



22. Has a doctor ever told you that you have Rheumatoid Arthritis?

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

Go to Question #29 on page 10.

23. Have you ever taken any of the following doctor-prescribed medications for Rheumatoid Arthritis?

<p>a. Methotrexate (meth-oh-TREKS-ayt) TSRAMET</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<p>NOT ELIGIBLE. Complete Box B.</p>
<p>b. Plaquenil (PLAK-wen-ill) TSRAPLA also called Hydroxychloroquine (hy-drox-ee-KLOR-oh-kwin)</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<p>NOT ELIGIBLE. Complete Box B.</p>
<p>c. Enbrel (EN-brel) also called Etanercept TSRAENB (eh-TAN-er-sept)</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<p>NOT ELIGIBLE. Complete Box B.</p>
<p>d. Remicade (REM-i-kade) TSRAREM also called Infliximab (in-FLIX-ih-mab)</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<p>NOT ELIGIBLE. Complete Box B.</p>
<p>e. Arava (uh-RAHV-uh or uh-RAVE-uh) also called Leflunomide (leh-FLOON-oh-myd) TSRAARA</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<p>NOT ELIGIBLE. Complete Box B.</p>
<p>f. Gold shots or pills TSRAGLD</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<p>NOT ELIGIBLE. Complete Box B.</p>
<p>g. Prednisone/steroids-glucocorticoids (PRED-nih-sohn) TSRAPRE (GLOO-koh-kor-tih-koyd)</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<p>NOT ELIGIBLE. Complete Box B.</p>
<p>h. Sulfasalazine (sul-fah-SAL-ah-zeen) TSRASUL</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<p>NOT ELIGIBLE. Complete Box B.</p>
<p>i. Kineret (KIN-a-ret) also called anti-IL1RA TSRAKIN</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<p>NOT ELIGIBLE. Complete Box B.</p>

Telephone Screening Interview

Screening 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"/>



TSSTFFH 24. In the morning, have you ever had joint stiffness in any joints lasting at least one hour?
 Yes No Don't know/Refused

← **24a.** Did you have this morning stiffness for more than 6 weeks?
 Yes No Don't know

Record 1

TSNOD 25. Have you ever had nodules or bumps under the skin around the elbow or ankle?

← Yes No Don't know/Refused

Record 1

26. Have you ever had swelling in any of the following joints lasting more than 6 weeks?

LEFT

RIGHT

TSWRSTL i.) Wrist?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
TSFINGL ii.) Any finger or thumb? (not joint closest to fingernail)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
TSELBL iii.) Elbow?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused
TSKNEEL iv.) Knee?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know/Refused

Interviewer Script: "We are nearly done with the interview. Please hold for a minute. I'll be right with you."

← **26a.** Interviewer: Are there 3 or more "Yes" responses to Questions #24a, #25, and #26?
 Yes No

Record 1

← **26b.** Interviewer: Is there at least one "Yes" response for any wrist or finger in Question #26?
 Yes No

Record 1

← **26c.** Interviewer: Is LEFT and RIGHT marked "Yes" for any one of the above joint categories, i.e., wrist, finger(s), elbow, or knee in Question #26?
 Yes No

Record 1

TSRABLD 27. Have you ever had a blood test for Rheumatoid Arthritis?
 Yes No Don't know/Refused

← What was the result?
 Positive Negative Don't know

Record 1

TSSCR4 TOTAL SCORE FOR QUESTIONS #24a THROUGH #27: (Add total from boxes above)

28. Is the TOTAL SCORE greater than or equal to 4? Yes No

Total Score **TSSCORE**

NOT ELIGIBLE.
Complete Box B.

Telephone Screening Interview

Screening 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"/>



29. Are you planning to move out of the area in the next three years?

- Yes
 No
 Don't know/Refused

NOT ELIGIBLE.
Complete Box B.

STAFF USE ONLY

(Interviewer Note: Complete these questions to determine eligibility.)

"We are nearly done with the interview. Please hold for a minute. I'll be right with you."

30. Did screenee answer "Don't know" to Question #17?

- Yes
 No

Mark **POTENTIALLY ELIGIBLE** in Box B.

31. Did screenee answer "Yes" or "Don't know" to Question #20?

- Yes
 No

Mark **POTENTIALLY ELIGIBLE** in Box B.

32. Are there any other reasons why you think the Recruitment Coordinator should confirm eligibility?

- Yes
 No

Mark **POTENTIALLY ELIGIBLE** in Box B.

Box B

POTENTIALLY ELIGIBLE

"Thank you for your time and for answering questions. You may be eligible for the MOST study. I need to confirm your eligibility. Someone from our office will be calling you back soon to let you know if you are eligible, and if so, to set up a study visit. Goodbye."
(Interviewer Note: Refer to Recruitment Coordinator.)

ELIGIBLE

"Thank you for your time and for answering our questions. The information will be very useful in the study. It does look like you are eligible to participate in this study."
(Interviewer Note: Read text from card about study visits.)

Appointment scheduled Date: _____ Time: _____

Call back for appointment Date: _____ Time: _____

NOT ELIGIBLE

"You are not eligible to be part of the study, but the information you provided will be very useful. Thank you for your time and for answering our questions. Goodbye."

NOT INTERESTED

"Can you tell me the reason you are not interested in participating?"
(Interviewer Note: Don't read list; Mark all that apply.)

No time/too busy

Too much trouble

Illness (self)

Illness (family member)

Afraid of potential medical finding during clinic visit

Don't like doctors/health care professionals

Concerned about radiation exposure

Concerned about pain/discomfort during clinic visit

Refused

Other *(Please specify: _____)*

"Thank you for your time and for answering our questions. Goodbye."

Baseline Self-Administered Questionnaire - Home



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

General Information

① Do you consider yourself to be Hispanic or Latino? **ETHNICITY**

1 Yes 0 No 8 Don't know

② What is your racial background? **RACE**
(Mark only one response.)

1 White or Caucasian 5 Hawaiian or Other Pacific Islander
 2 Black or African American 6 More than one race *(Please specify: _____)*
 3 Asian 7 Other *(Please specify: _____)*
 4 American Indian or Alaskan Native 8 Don't know

③ What is your current marital status? **VOMARRY**

1 Married or living in a married-like relationship 5 Single, never married
 2 Widowed 6 Other *(Please specify: _____)*
 3 Separated 8 No answer
 4 Divorced

④ Do you live by yourself or do you live with a spouse, family member(s), or roommate(s)?

V0ALONE 1 Live alone 2 Live with my spouse, family member(s), or roommate(s)

⑤ Please mark the highest grade or year of school that you completed.
(Mark only one response.)

V0EDUC

1 Some elementary school
 2 Elementary school (completed grade 8)
 3 Some high school
 4 High school graduate (completed grade 12)
 5 Some college
 6 College graduate
 7 Some graduate school
 8 Graduate degree

Height and Weight 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"/> <input type="text"/> <input type="text"/> <input type="text"/>



- ⑥ How tall were you without shoes when you were about 25 years old? If you don't remember exactly, give your best estimate.

V0HTFT feet inches **V0HTIN**

- ⑦ What was your usual weight when you were about 25 years old? If you don't remember exactly, give your best estimate. (**Women, answer for a time when you were not pregnant.**)

V0WT25 pounds

- ⑧ What is the most you have ever weighed, and how old were you when you were at your heaviest weight? If you don't remember exactly, give your best estimate. (**Women, answer for a time when you were not pregnant.**)

V0WTMAX pounds at years of age **V0WTAGE**

V0_HT25

V0_WGHT25

V0_BMI25

Joint Pain, Aching, and Stiffness

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"/>



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

VOJPAIN

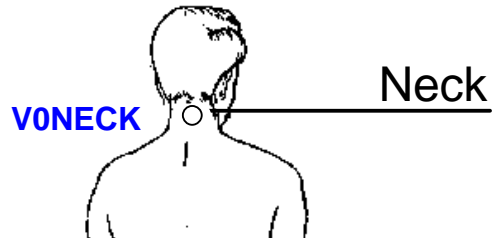
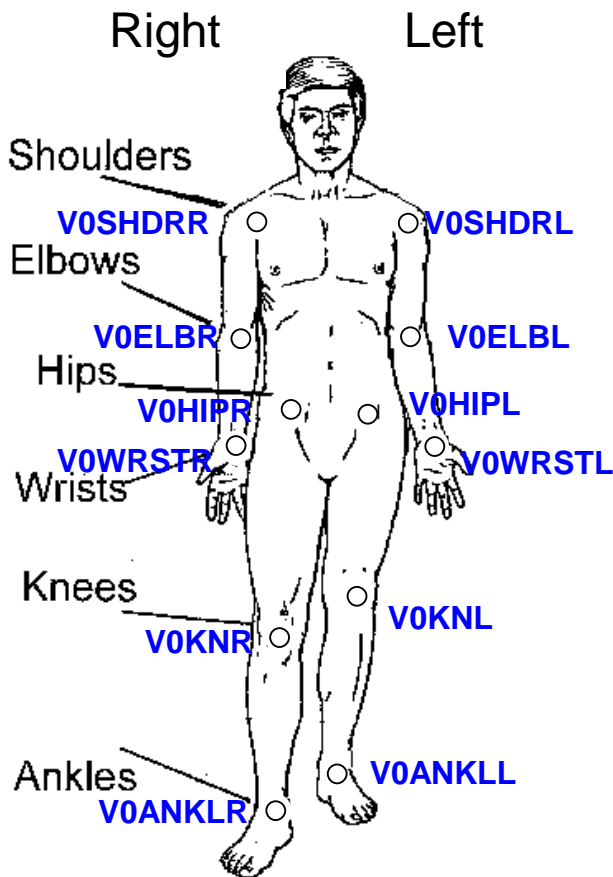
1 Yes

0 No

8 Don't know

Go to Question #10 on page 6.

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.)



V0_WSPA
V0_WSPB
V0_WSPC

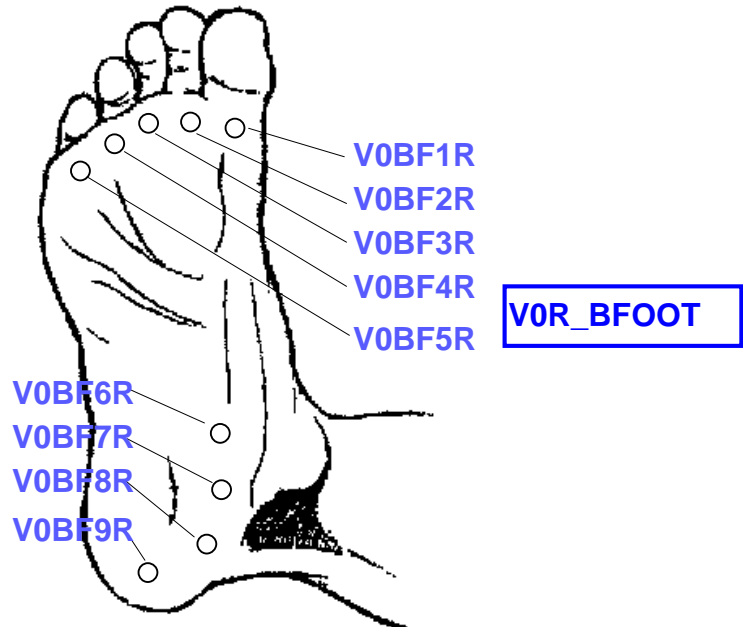
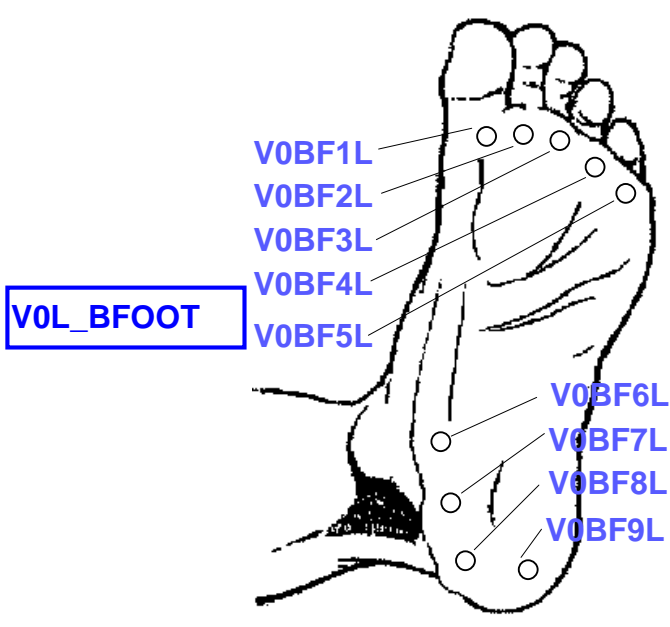
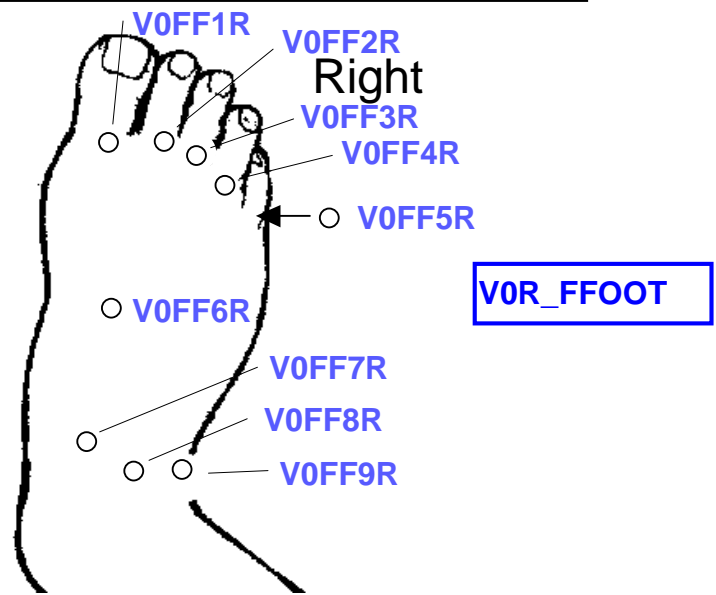
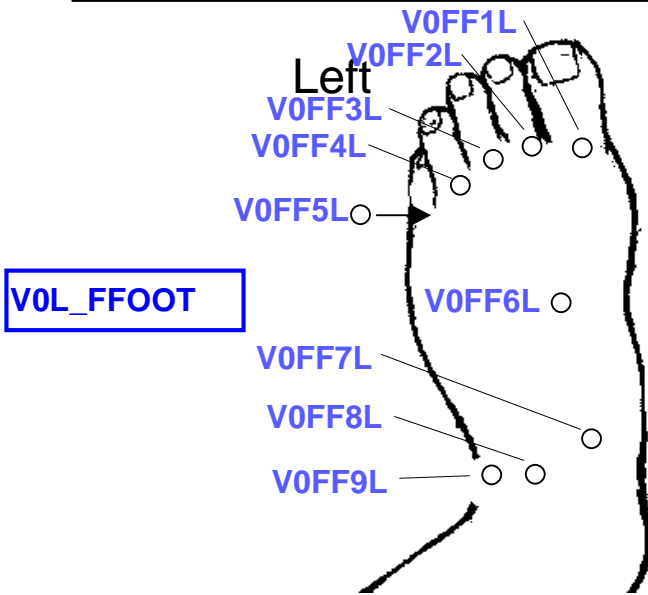
1 = YES

Joint Pain, Aching, and Stiffness

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



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.*)



Joint Pain, Aching, and Stiffness

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"/>



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.*)

Left Right

V0L_HAND

V0R_HAND

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



⑩ During **the past 30 days**, have you had any back pain?

VOPAIN

1 Yes
 0 No
 8 Don't know

Go to Question #11 on page 7.

- VOFREQ** 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
- VOSERV** 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**)

LOWER BACK

CLINIC USE ONLY

VONK NK

VOUB UB

VOMB MB

VOLB LB

VOBK BK

1 = YES

V0_LBP

VOBPLA d. During the **past 30 days**, have you limited your activities because of back pain?
 1 Yes 0 No → Go to Question #11 on page 7.

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

VOBDDAY days

How many days did you limit your activities because of your back?
 (Do **not** include days in bed.)

VOBPLAD days



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"/>

Arthritis Diagnosis

11 Has a doctor ever told you that you have arthritis?

VOARTH ¹ Yes
 ⁰ No
 ⁸ Don't know

Go to Question #12 on page 8.

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

- VORA a. Rheumatoid arthritis? ¹ Yes ⁰ No ⁸ Don't know
- VOKNOA b. Osteoarthritis or degenerative arthritis in your knee? ¹ Yes ⁰ No ⁸ Don't know
- VOHPOA c. Osteoarthritis or degenerative arthritis in your hip? ¹ Yes ⁰ No ⁸ Don't know
- VOHFOA d. Osteoarthritis or degenerative arthritis in your hand or fingers? ¹ Yes ⁰ No ⁸ Don't know
- VOOJOA e. Osteoarthritis or degenerative arthritis in some other joint? ¹ Yes ⁰ No ⁸ Don't know
- VOGOUT f. Gout? ¹ Yes ⁰ No ⁸ Don't know
- VOOOTH g. Some other type of arthritis? ¹ Yes ⁰ No ⁸ Don't know
 (Please specify: _____)

VOARTHRX h. Are you taking any of the following medications for your arthritis every day or almost every day?

<ul style="list-style-type: none"> ◆ Aspirin ◆ Ibuprofen (for example, Advil or Motrin) ◆ Tylenol (Acetaminophen) 	<ul style="list-style-type: none"> ◆ Cox2 inhibitors (e.g. Celebrex or Vioxx) ◆ Other Nonsteroidals/Anti-inflammatories (for example, Diclofenac, Voltaran, Sulindac [Clinoril], Naprosyn, Indomethacin)
¹ <input type="radio"/> Yes ⁰ <input type="radio"/> No	⁸ <input type="radio"/> Don't know

VOSTEROD i. In the past 12 months have you had a steroid injection (cortisone) in either of your knees for treatment of your arthritis?

¹ Yes
 ⁰ No
 ⁸ Don't know

VOSTKN In which knee?

¹ Right knee
 ² Left knee
 ³ Both
 ⁸ Don't know/Refused

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



12 Has anyone in your immediate family (that is, either your mother, father, sister, brother or child) been told that they have arthritis? **(Please answer for biological [blood] relatives only.)**

1 Yes 0 No 8 Don't know **V0FARTH**

Was it your... (Please answer for each family member.)	
Mother?	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 8 <input type="radio"/> Don't know VOMOM</p> <p>Was the arthritis in her knee(s)?</p> <p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 8 <input type="radio"/> Don't know VOMOMKN</p>
Father?	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 8 <input type="radio"/> Don't know VODAD</p> <p>Was the arthritis in his knee(s)?</p> <p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 8 <input type="radio"/> Don't know VODADKN</p>
Sister(s)? (One or more)	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 2 <input type="radio"/> Don't have sister(s) 8 <input type="radio"/> Don't know VOSIS</p> <p>Was the arthritis in her (their) knee(s)?</p> <p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 8 <input type="radio"/> Don't know VOSISKN</p>
Brother(s)? (One or more)	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 2 <input type="radio"/> Don't have brother(s) 8 <input type="radio"/> Don't know VOBRO</p> <p>Was the arthritis in his (their) knee(s)?</p> <p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 8 <input type="radio"/> Don't know VOBROKN</p>
Child(ren)? (biological/ blood) (One or more)	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 2 <input type="radio"/> Don't have children 8 <input type="radio"/> Don't know VOCHD</p> <p>Was the arthritis in his (their) knee(s)?</p> <p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 8 <input type="radio"/> Don't know VOCHDKN</p>



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

Health History and Medical Conditions

13) Have you ever had a heart attack?

1 Yes

0 No

8 Don't know

VOHRTAT

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

1 Yes

0 No

8 Don't know

VOUNCLOG

15) 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

VOHRTFA

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

1 Yes

0 No

8 Don't know

VOBYPASS

17) 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

VOSTROKE

Go to Question #18.

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

VOMOVE

18) Do you have asthma?

1 Yes

0 No

8 Don't know

VOASTHMA

Go to Question #19 on page 10.

Do you take medicines for your asthma?

1 Yes

0 No

8 Don't know

VOASTRX

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

VOWHEN

Health History and Medical Conditions

(continued)

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 have emphysema, chronic bronchitis, or chronic obstructive lung disease? **V0COPD**

1 Yes 0 No 8 Don't know

Go to Question #20.

Do you take medicines for your lung disease? **V0LUNRX**

1 Yes 0 No 8 Don't know

When do you usually take the medicine? (**Please mark one.**) **V0LWHEN**

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

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

20 Do you have stomach ulcers, or peptic ulcer disease? **V0ULCER**

1 Yes 0 No 8 Don't know

Go to Question #21.

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)? **V0ULCDX**

1 Yes 0 No 8 Don't know

21 Do you have diabetes (high blood sugar)? **V0DIABT**

1 Yes 0 No 8 Don't know

Go to Question #22 on page 11.

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

V0DIET modifying my diet

V0DRX medications taken by mouth

V0INJ insulin injections

V0NONE not treated **1 = YES**

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

V0KID Problems with your kidneys

V0EYE Problems with your eyes, treated by an ophthalmologist

V0ODDK Has not caused problems

Health History and Medical Conditions

(continued)

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"/>



22 Have you ever had serious problems with your kidneys?
 1 Yes 0 No 8 Don't know

VOKIDNY

Go to Question #23.

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

Poor kidney function (blood tests show high creatinine) VOPOORF

Have received a kidney transplantation VOTRANS

Have used hemodialysis or peritoneal dialysis VODIALY

Other **(Please specify: _____)** VOKOTR

Don't know VODK

1 = YES

23 Do you have any of the following conditions?

a. Alzheimer's Disease, or another form of dementia? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	V0ALZHE
b. Cirrhosis, or serious liver damage? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	V0LIVER
c. Leukemia or polycythemia vera? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	V0LEUKE
d. Lymphoma? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	V0LYMPH
e. Cancer, other than skin cancer, leukemia or lymphoma? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	V0CANCER
<div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> Has the cancer spread, or metastasized to other parts of your body? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </div>	V0CANCERS
f. AIDS? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	V0AIDS

V0_DX

V0MCOMOR

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"/>



24 Has a doctor ever told you that you broke or fractured a bone after the age of 45?

V0BONE 1 Yes 0 No 8 Don't know

Go to Question #25.

Has a doctor ever told you that you broke or fractured your hip?

V0FXHIP 1 Yes 0 No 8 Don't know

How old were you when a doctor first told you this?
If you are unsure, please make your best guess.

V0HPAGE I was years old. Don't know **V01HPDK**

25 Has a doctor ever told you that you had a fracture of the spine or fracture of the vertebrae?

V0SPINE 1 Yes 0 No 8 Don't know

Go to Question #26.

How old were you when a doctor first told you this?
If you are unsure, please make your best guess.

I was years old. Don't know **V0SPDK**

V0SPAGE

V0_FXHIPSP



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

Tobacco Use

26 Have you smoked at least 100 cigarettes (5 packs) in your entire life?

VOSMOKE

1 Yes

0 No

Go to Question #27.

How old were you when you first started smoking regularly?
If unsure, please make your best guess.

VOSKAGE
years old

On the average of the entire time you smoked, how many
cigarettes did you smoke per day?

VOSKAVE
per day

Do you smoke cigarettes now?

VOSKNOW 1 Yes

0 No

VOSMK

About how many cigarettes
do you smoke per day?

VOSKAMT
per day

How old were you when you
stopped smoking?

VOSKSTP
years old

VOPACKYR

27 Have you ever used chewing tobacco or snuff on a regular basis?

VOCHEW

1 Yes

0 No

Go to Question #28.

How old were you when you first started using chewing
tobacco or snuff fairly regularly?

VOCHAGE
years old.

Do you use snuff or chewing tobacco now?

VOCHNOW 1 Yes

0 No

About how many containers
do you use per week?

VOCHAMT
per week

How old were you when you last used
snuff or chewing tobacco fairly regularly?

VOCHSTP
years old

28 Have you ever smoked a pipe or cigars regularly?

VOPIPE

1 Yes

0 No

Go to Question #29
on page 14.

For how many years?

VOPIYR
years

About how many pipes or cigars
did/do you smoke per week?

VOPIAMT
per week

VO_SMK3



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

Current Employment

- 29 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.)

VOPAY 1 Yes 0 No 8 Don't know

Go to Question #30.

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.)

VONOPAY 1 Yes 0 No 8 Don't know

Go to Question #30.

V0HLTH

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

1 Yes 0 No 8 Don't know

Go to Question #32 on page 15.

- 30 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.)*

V0HRSWK

Number of hours worked per week

- 31 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.)*

V0MIS

Number of days missed in the past 3 months



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"/>

Work History

③② What kind of work have you done most of your adult life? (*Please choose ONE answer.*)

- VOWKIND**
- 1 skilled/craftsman
 - 2 sales
 - 3 farming
 - 4 technician
 - 5 office/clerical
 - 6 office/professional
 - 7 unskilled/semi-skilled labor
 - 8 worked in the home
 - 9 other (*Please specify:* _____)

③③ How many years did you do this work? (*Please choose ONE answer.*)

- VOWYEAR**
- 1 0- 5 years
 - 2 6-10 years
 - 3 11-15 years
 - 4 16-20 years
 - 5 21-25 years
 - 6 26-30 years
 - 7 31-35 years
 - 8 36-40 years
 - 9 more than 40 years

③④ What is or was your level of physical activity in the work you have done most of your adult life? This includes if you worked at home. (*Please choose ONE answer.*)

- VOPALEV**
- 1 Mainly sitting with slight arm movements.
(Examples: office worker, watchmaker, seated assembly line worker, bus driver, etc.).
 - 2 Sitting or standing with some walking.
(Examples: cashier, general office worker, light tool and machinery worker).
 - 3 Walking, with some handling of materials generally weighing less than 50 pounds. (Examples: mailman, waiter/waitress, construction worker, heavy tool and machinery worker).
 - 4 Walking and heavy manual work often requiring handling of materials weighing over 50 pounds. (Examples: stone mason, farm or general laborer).

Work History (continued)

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



Think of the following questions in terms of a typical work day for any work that you have done. This includes if you worked at home.

35 Did you ever do work that required you to drive a motor vehicle for 4 hours or more nearly every day?

V0DRIVE

1 Yes

0 No

8 Don't know

Go to Question #36.

V0DRYR

a. How many years did you do this? years

V0_DRYRCAT

V0DRNOW

b. Are you still doing this?

1 Yes

0 No

8 Don't know

36 Did you ever do work that required you to bend over at the waist repeatedly for 2 hours or more nearly every day?

V0BEND

1 Yes

0 No

8 Don't know

Go to Question #37.

V0BNYR

a. How many years did you do this? years

V0_BNYRCAT

V0BNNOW

b. Are you still doing this?

1 Yes

0 No

8 Don't know

37 Did you ever do work that required you to walk for 2 hours or more nearly every day?

V0WLKA

1 Yes

0 No

8 Don't know

Go to Question #38 on page 17.

V0WAYR

a. How many years did you do this? years

V0_WAYRCAT

V0WANOW

b. Are you still doing this?

1 Yes

0 No

8 Don't know

Work History (continued)

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"/>



Think of the following questions in terms of a typical work day for any work that you have done.

38 Did you ever do work that required you to walk for 2 hours or more over rough ground or uneven surface nearly every day?

V0WLKB

1 Yes

0 No

8 Don't know

Go to Question #39.

V0WBYR

a. How many years did you do this? years

V0_WBYRCAT

V0WBNOW

b. Are you still doing this?

1 Yes

0 No

8 Don't know

39 Did you ever do work that required you to stand for 2 hours or more nearly every day?

V0STAND

1 Yes

0 No

8 Don't know

Go to Question #40.

V0STYR

a. How many years did you do this? years

V0_STYRCAT

V0STNOW

b. Are you still doing this?

1 Yes

0 No

8 Don't know

40 Did you ever do work that required you to kneel for 30 minutes or more nearly every day?

V0WKNEEL

1 Yes

0 No

8 Don't know

Go to Question #41 on page 18.

V0KLYR

a. How many years did you do this? years

V0_KLYRCAT

V0KLNOW

b. Are you still doing this?

1 Yes

0 No

8 Don't know

Work History (continued)

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"/>



Think of the following questions in terms of a typical work day for any work that you have done.

- ④① Did you ever do work that required you to squat for 30 minutes or more nearly every day?

V0SQAT 1 Yes 0 No 8 Don't know

Go to Question #42.

V0SQYR

a. How many years did you do this? years

V0_SQYRCAT

V0SQNOW

b. Are you still doing this?

1 Yes

0 No

8 Don't know

- ④② Did you ever do work that required you to climb up or down a total of 10 or more flights of stairs nearly every day? (One flight is about 10 steps.)

V0CLIMB 1 Yes 0 No 8 Don't know

Go to Question #43.

V0CLYR

a. How many years did you do this? years

V0_CLYRCAT

V0CLNOW

b. Are you still doing this?

1 Yes

0 No

8 Don't know

- ④③ Did you ever do work that required you to lift or move objects weighing 25 pounds or more nearly every day?

V0LIFT 1 Yes 0 No 8 Don't know

Go to Question #44 on page 19.

V0LFYR

a. How many years did you do this? years

V0_LFYRCAT

V0LFNOW

b. Are you still doing this?

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

Everyday Things

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

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

To what extent do you feel limited in...?	Not at all	A little	Somewhat	A lot	Completely
④④ Visiting friends and family in their homes.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/> V0FDI1
④⑤ Providing care or assistance to others. This may include providing personal care, transportation, and running errands for family members or friends.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/> V0FDI2
④⑥ Taking care of the inside of your home. This includes managing and taking responsibility for homemaking, laundry, housecleaning and minor household repairs.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/> V0FDI3
④⑦ Working at a volunteer job outside your home.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/> V0FDI4
④⑧ Taking part in active recreation. This may include bowling, golf, tennis, hiking, jogging, or swimming.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/> V0FDI5
④⑨ Traveling out of town for at least an overnight stay.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/> V0FDI6
⑤⑩ Taking part in a regular fitness program. This may include walking for exercise, stationary biking, weight lifting, or exercise classes.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/> V0FDI7
⑤① Going out with others to public places such as restaurants or movies.	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/> V0FDI8

Everyday Things (continued)

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"/>



To what extent do you feel limited in...?	Not at all	A little	Somewhat	A lot	Completely
52 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"/> V0FDI9
53 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"/> V0FDI10
54 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"/> V0FDI11
55 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"/> V0FDI12

VOLLDIIR



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

Health Survey

This survey asks for your views about your health.

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

56 In general, would you say your health is:

- V0SF1
- 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
57 <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf V0SF2	1 <input type="radio"/>	2 <input type="radio"/>	0 <input type="radio"/>
58 Climbing <u>several</u> flights of stairs V0SF3	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?

59 <u>Accomplished less</u> than you would like V0SF4	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
60 Were limited in the <u>kind</u> of work or other activities V0SF5	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)?

61 <u>Accomplished less</u> than you would like V0SF6	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know
62 Didn't do work or other activities as <u>carefully</u> as usual V0SF7	1 <input type="radio"/> Yes	0 <input type="radio"/> No	8 <input type="radio"/> Don't know

Health Survey (continued)

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"/>



63 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.)**

V0SF8

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 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
V0SF9 64 Have you felt calm and peaceful? V0SF10	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	0 <input type="radio"/>
65 Did you have a lot of energy? V0SF11	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	0 <input type="radio"/>
66 Have you felt downhearted and blue?	5 <input type="radio"/>	4 <input type="radio"/>	3 <input type="radio"/>	2 <input type="radio"/>	1 <input type="radio"/>	0 <input type="radio"/>

67 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.)**

- All of the time Most of the time Some of the time A little of the time None of the time
 V0SF12 4 3 2 1 0

V0SF12MM

V0SF12MP



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 Survey (continued)

- 68 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.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	VOCESDA
b. I did not feel like eating: my appetite was poor.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	VOCESDB
c. I felt that I could not shake off the blues even with help from my family and friends.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	VOCESDC
d. I felt that I was just as good as other people.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	VOCESDD
e. I had trouble keeping my mind on what I was doing.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	VOCESDE
f. I was depressed.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	VOCESDF
g. I felt that everything I did was an effort.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	VOCESDG
h. I felt hopeful about the future.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	VOCESDH
i. I thought my life had been a failure.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	VOCESDI
j. I felt fearful.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	VOCESDJ

Health Survey (continued)

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"/>



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"/>	V0CESDK
l. I was happy.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	V0CESDL
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"/>	V0CESDM
n. I felt lonely.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	V0CESDN
o. People were unfriendly.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	V0CESDO
p. I enjoyed life.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	V0CESDP
q. I had crying spells.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	V0CESDQ
r. I felt sad.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	V0CESDR
s. I felt that people disliked me.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	V0CESDS
t. I could not get going.	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	V0CESDT

V0CES_D

V0_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 the top of pages 1 and 2, all of pages 3 through 5 and 7 through 8 of the MOST Baseline 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	V0Q1KR	V0Q1KL
Up stairs	V0UPR	V0UPL
Down stairs	V0DOWNR	V0DOWNL
Stairs (calculated)	V0Q2KR	V0Q2KL
In bed	V0Q3KR	V0Q3KL
Sit or lie down	V0Q4KR	V0Q4KL
Standing	V0Q5KR	V0Q5KL

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: V0UPR, V0UPL, V0DOWNR, and V0DOWNL. “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	V0WOPNKR	V0WOPNKL

(Note: the top of pages 1 and 2, all of pages 3 through 5 and 7 through 8 of the MOST Baseline Self-Administered Questionnaire – Clinic are not being displayed.)



Knee stiffness

The individual items in the stiffness subscale are:

<u>Activity</u>	<u>Variable (right knee)</u>	<u>Variable (left knee)</u>
In morning	V0Q6KR	V0Q6KL
Later in day	V0Q7KR	V0Q7KL

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	V0WOSTKR	V0WOSTKL

Disability

The individual items in the disability subscale are:

<u>Activity</u>	<u>Variable (either knee)</u>
Down stairs	V0Q8K
Up stairs	V0Q9K
Stand from sitting	V0Q10K
Standing	V0Q11K
Bending	V0Q12K
Walking	V0Q13K
In car/out of car	V0Q14K
Shopping	V0Q15K
Socks on	V0Q16K
Get out of bed	V0Q17K
Socks off	V0Q18K
Lying down	V0Q19K
Bathing	V0Q20K
Sitting	V0Q21K
On/off toilet	V0Q22K
Heavy chores	V0Q23K
Light chores	V0Q24K

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: V0Q8K, V0Q9K, V0Q12K, V0Q15K, V0Q23K, and V0Q24K. “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	V0WOPASK

(Note: the top of pages 1 and 2, all of pages 3 through 5 and 7 through 8 of the MOST Baseline Self-Administered Questionnaire – Clinic are not being displayed.)



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	V0WOTOTR	V0WOTOTL

Hip pain

The individual items in the pain subscale are:

<u>Activity</u>	<u>Variable (right knee)</u>	<u>Variable (left knee)</u>
Walking	V0Q1HR	V0Q1HL
Up/down stairs	V0Q2HR	V0Q2HL
In bed	V0Q3HR	V0Q3HL
Sit or lie down	V0Q4HR	V0Q4HL
Standing	V0Q5HR	V0Q5HL
Socks on	V0Q6HR	V0Q6HL
In chair/out of chair	V0Q7HR	V0Q7HL
In car/out of car	V0Q8HR	V0Q8HL

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: V0Q2HR and V0Q2HL. "Don't do" is set to missing.

The pain subscale scores are calculated for the right and left hip separately. V0WOPNHR and V0WOPNHL are standard calculations and V0WOPHRM and V0WOPHLM 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	V0WOPNHR	V0WOPNHL
Pain/disability subscale scores	V0WOPHRM	V0WOPHLM

(Note: the top of pages 1 and 2, all of pages 3 through 5 and 7 through 8 of the MOST Baseline Self-Administered Questionnaire – Clinic are not being displayed.)

MOST Baseline
Self-Administered Questionnaire – Clinic



Score calculations

An individual response of:

5 = Don't do

.M = Missing

For any item is treated as missing data.

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

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

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

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

(Note: the top of pages 1 and 2, all of pages 3 through 5 and 7 through 8 of the MOST Baseline Self-Administered Questionnaire – Clinic are not being displayed.)

MOST Baseline
Self-Administered Questionnaire – Clinic

Baseline Self-Administered Questionnaire - Clinic



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

Note: WOMAC© was removed from this page. See "Scoring for WOMAC©" documentation on page [35].

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")



no
pain

VOVASKR

Clinic Use Only
<input type="text"/>

pain as
bad as it
could be

Knee Symptoms

(continued)

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"/>



Note: WOMAC© was removed from this page. See "Scoring for WOMAC©" documentation on page [35].

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")



no
pain

V0VASKL

Clinic Use Only
<input type="text"/>
<input type="text"/>
<input type="text"/>

pain as
bad as it
could be



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"/>

Physical Difficulty

(continued)

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		V0SP1K
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		V0SP2K
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		V0SP3K
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		V0SP4K
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		V0SP5K

V0KOOSSP



PASE[©] Scoring

The Physical Activity Scale for the Elderly (PASE[©]) is a registered trademark, PASE[©] 1991 New England Research Institutes, Inc. This copyrighted instrument may not be displayed. Therefore pages 1, top of 2, and 3 through 5 of the MOST Baseline Clinic Interview are not being displayed.

Please go to:

http://www.neriscience.com/web/MultiPiecePage.asp?Q_PageID=E_71_A_PageName=E_instrumentsforsale#88

for more information about the PASE[©].

PASE[©] domains

The PASE[©] covers 3 domains of activity: leisure activities, household activities and occupational activities. The time period covered by PASE[©] is the “past 7 days”.

Leisure activities

The individual leisure activity items are:

<u>Activity</u>	<u>Variable (days/week)</u>	<u>Variable (hours/day)</u>	<u>Variable (calculated)</u>
Sitting	VOSIT	VOSITT	V0PASE01
Walking	V0WALK	V0WALKT	V0PASE02
Light sport/recreation	VOLTE	VOLTET	V0PASE03
Moderate sport/recreation	V0MOD	V0MODT	V0PASE04
Strenuous sport/recreation	V0STR	V0STRT	V0PASE05
Muscle strength/endurance	V0WGT	V0WGTT	

Each activity is scored for frequency using a 4-point scale:

- 0 = Never
- 1 = Seldom (1-2 days)
- 2 = Sometimes (3-4 days)
- 3 = Often (5-7 days)

and for hours per day using a 4-point scale:

- 1 = Less than 1 hour
- 2 = Between 1 and 2 hours
- 3 = 2 to 4 hours
- 4 = More than 4 hours

(Note: Pages 1, top of 2, and 3 through 5 of the MOST Baseline Clinic Interview are not being displayed.)



Household activities

The individual household activity items are:

<u>Activity</u>	<u>Variable (activity)</u>	<u>Variable (calculated)</u>
Light housework	VOLHW	VOPASE06
Heavy housework	VOHHW	VOPASE07
Home repairs	VOHOME	VOPASE08
Lawn work/yard care	VOLAWN	VOPASE09
Outdoor gardening	VOGARDN	VOPASE10
Caring for another person	VO CARE	VOPASE11

Each household activity item is scored:

- 0 = No
- 1 = Yes
- .M = Don't know/Refused

Occupational activities

The individual occupational items are:

<u>Item</u>	<u>Variable (activity)</u>	<u>Variable (calculated)</u>
Work (pay/volunteer)	VOWK	VOPASE12

The work (pay/volunteer) item is scored:

- 0 = No
- 1 = Yes
- .M = Don't know/Refused

<u>Item</u>	<u>Variable</u>
Number of hours worked	VOWKHR

<u>Item</u>	<u>Variable</u>
Occupational activity level	VOWKPA

The activity level item is scored on a 4-point scale:

- 1 = Sitting
- 2 = Sitting/standing/walking
- 3 = Walking/handling <50 lbs
- 4 = Walking/handling >50 lbs
- .M = Don't know

(Note: Pages 1, top of 2, and 3 through 5 of the MOST Baseline Clinic Interview are not being displayed.)



Total score

12 items are weighted depending on the strenuousness of the activity, and then summed to give the PASE[©] total score. PASE scores are summary values calculated from weights and frequencies for each of the 12 types of activities described in the questionnaire. Q1 on page 1 (sitting activities over the past 7 days) and Q4 on page 2 (climbed flight of stairs over the past 7 days) were administered as part of the PASE questionnaire, but did not contribute to the overall PASE score. Q8-Q11 have been given an option “Don’t know/Refused” – all such responses were converted into missing values before calculation. If all PASE components are missing, then score set up as missing value. There are no substitutions made for missing or skipped questions. If at least one component of the score is non-missing,

For a more detailed description of the PASE calculation, see the document: Calculated Variable Descriptions and SAS Code.

Score

Variable

Total score

V0PASE

Score calculations

The leisure activity items are translated to the midpoints of the frequency range (i.e., 0, 1.5, 3.5, or 6, respectively, for days of the week). The hours per day are translated to the midpoints of the hours range (i.e., .5, 1.5, 3, or 5, respectively). Hours per day is then calculated for each leisure activity item (freq*hrs/7).

If the less than 1 hour worked item (WORK1HR) is answered less than 1 hour, this item is calculated as 1 hour worked for the total score.

An individual response of:

.M = Don’t know/Refused

for any leisure activity frequency item or household activity item is treated as missing data and the total score is set to missing.

(Note: Pages 1, top of 2, and 3 through 5 of the MOST Baseline Clinic Interview are not being displayed.)

MOST Baseline
Clinic Interview

Physical Activity

(continued)

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"/>



Note: PASE© was removed from this page. See "Scoring for PASE©" documentation on page [42].

- ④ Over the past 7 days, how many flights of stairs have you climbed up?
(Interviewer Note: One flight is equal to about 10 steps. REQUIRED - Show Card #7.)

V0STAIR

- 1 Less than one flight
- 2 1 flight but less than 2 flights
- 3 2 flights but less than 4 flights
- 4 4 flights but less than 6 flights
- 5 6 or more flights



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

Knee Symptoms

The next questions are about pain, aching, or stiffness in or around your knees.

Right Knee

First I'll ask you about your right knee.

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

V0KPN12R

1 Yes

0 No

8 Don't know/Refused

⑫a 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 #14.

V0MNTHR

⑬ During the past 30 days, have you had any pain, aching, or stiffness in your right knee?

V0PN30R

1 Yes

0 No

8 Don't know/Refused

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

V0KPN30R

1 Yes

0 No

8 Don't know

Interviewer Note: Record that participant has right knee pain on the Knee and Hip Exam form (page 19 in the Clinic Visit Workbook).

Go to Question #14.

V0R_FKP

V0R_SX

Knee Symptoms

(continued)

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



Left Knee

Now I'll ask you about your left knee.

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

V0KPN12L

1 Yes

0 No

8 Don't know/Refused

14a During the past 12 months, have you had pain, aching, or stiffness in your left knee on most days for at least one month?

Go to Question #16.

V0MNTHL

1 Yes

0 No

8 Don't know

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

V0PN30L

1 Yes

0 No

8 Don't know/Refused

Go to Question #16.

15a During the past 30 days, have you had pain, aching, or stiffness in your left knee on most days?

V0KPN30L

1 Yes

0 No

8 Don't know

Interviewer Note: Record that participant has left knee pain on the Knee and Hip Exam form (page 19 in the Clinic Visit Workbook).

Go to Question #16.

V0L_FKP

V0L_SX

Both Knees

16 During the past 30 days, have you limited your activities because of pain, aching, or stiffness in either knee?

V0KNLA

1 Yes

0 No

8 Don't know/Refused

16a On how many days did you limit your activities because of pain, aching, or stiffness?

V0KNLAD

days

16b 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 V0AVOID

V0_FKPSX



MOST ID #	Acrostic
<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.

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

- V0KBUCK** 1 Yes 0 No 8 Don't know/Refused

Go to Question #22.

18) Which knee buckled or gave way at least once?

- V0KBS** 1 Right knee 2 Left knee 3 Both knees 8 Don't know which knee/Refused

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

- V0KBTOT** 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

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

- V0FALL** 1 Yes 0 No 8 Don't know/Refused

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

(Interviewer Note: Please mark all that apply.)

- V0WLK** Walking
V0STAIRB Going up or down stairs
V0TWIST Twisting or turning
V0KBOT Other (**Please specify:** _____)
V0KBDK Don't know/Refused

Knee Injury and/or Surgery

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



Right Knee

22) Have you ever injured your right knee badly enough to limit your ability to walk for at least two days?

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

How old were you when you injured your knee?
(Interviewer Note: If more than once, record age when each injury occurred.)

V0WAG1R years old **VOR_INJYR**

V0WAG2R years old Don't know V0WDKR

V0WAG3R years old

23) Have you ever had surgery in your right knee?

V0SURGR 1 Yes 0 No 8 Don't know/Refused

Go to Question #29.

24) Did you have a right total knee replacement, where all or part of the joint was replaced?

VOR_TKR * 1 Yes 0 No

a. How old were you when you first had your right knee replaced?

V0KAG1R years old Don't know **VOR_TKRYR**

b. Was this knee replacement surgery to repair an injury? **VOKINJR**

Yes No Don't know

* Variable is derived from self-report and radiographic adjudication.

Knee Injury and/or Surgery

(continued)

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"/>



25 Did you have arthroscopy (where they put a scope) in your right knee?
VOARTR **1** Yes **0** No **8** Don't know/Refused

a. How old were you when you had the arthroscopy surgery?
(Interviewer Note: If more than once, record age when each surgery occurred.)

V0AAG1R	<input type="text"/> <input type="text"/> years old	V0R_ARTYR	
V0AAG2R	<input type="text"/> <input type="text"/> years old	<input type="radio"/> Don't know	V0ADKR
V0AAG3R	<input type="text"/> <input type="text"/> years old		

b. Was this arthroscopy surgery to repair an injury?
VOAINJR **1** Yes **0** No **8** Don't know

26 Did you ever have a meniscectomy (where they repaired or cut away a torn meniscus or cartilage) in your right knee?
VOMENR **1** Yes **0** No **8** Don't know/Refused

a. How old were you when you had this surgery?
(Interviewer Note: If more than once, record age when each surgery occurred.)

V0MAG1R	<input type="text"/> <input type="text"/> years old	V0R_MENYR	
V0MAG2R	<input type="text"/> <input type="text"/> years old	<input type="radio"/> Don't know	V0MDKR
V0MAG3R	<input type="text"/> <input type="text"/> years old		

b. Was this surgery to repair an injury?
VOMINJR **1** Yes **0** No **8** Don't know

Knee Injury and/or Surgery

(continued)

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"/>



VOLIGR (27) Did you ever have a ligament repair in your right knee?
 1 Yes 0 No 8 Don't know/Refused

a. How old were you when you had this ligament repair surgery?
(Interviewer Note: If more than once, record age when each surgery occurred.)

V0LAG1R	<input type="text"/> <input type="text"/> years old	V0R_LIGYR	
V0LAG2R	<input type="text"/> <input type="text"/> years old	<input type="radio"/> Don't know	V0LDKR
V0LAG3R	<input type="text"/> <input type="text"/> years old		

b. Was this ligament surgery to repair an injury?
 1 Yes 0 No 8 Don't know

VOLINJR

VOSOTHR (28) Did you have another kind of surgery in your right knee?
 1 Yes 0 No 8 Don't know/Refused

a. What kind of surgery was this? _____
 Don't know **V0SDK1R**

b. How old were you when you had this surgery?
(Interviewer Note: If more than once, record age when each surgery occurred.)

V0SAG1R	<input type="text"/> <input type="text"/> years old	V0R_OTHYR	
V0SAG2R	<input type="text"/> <input type="text"/> years old	<input type="radio"/> Don't know	V0SDKR
V0SAG3R	<input type="text"/> <input type="text"/> years old		

c. Was this surgery to repair an injury?
 1 Yes 0 No 8 Don't know

VOSINJR

Knee Injury and/or Surgery

(continued)

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



Left Knee

29 Have you ever injured your left knee badly enough to limit your ability to walk for at least two days?

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

How old were you when you injured your knee?
(Interviewer Note: If more than once, record age when each injury occurred.)

V0WAG1L years old **VOL_INJYR**

V0WAG2L years old Don't know V0WDKL

V0WAG3L years old

30 Have you ever had surgery in your left knee?

V0SURGL 1 Yes 0 No 8 Don't know/Refused

Go to Question #36.

31 Did you have a left total knee replacement, where all or part of the joint was replaced?

VOL_TKR * 1 Yes 0 No

a. How old were you when you first had your left knee replaced? **VOL_TKRYR**

V0KAG1L years old Don't know V0KDKL

b. Was this knee replacement surgery to repair an injury? **VOKINJL**

1 Yes 0 No 8 Don't know

* Variable is derived from self-report and radiographic adjudication.

Knee Injury and/or Surgery

(continued)

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"/>



32 Did you have arthroscopy (where they put a scope) in your left knee?
VOARTL **1** Yes **0** No **8** Don't know/Refused

a. How old were you when you had this arthroscopy surgery?
(Interviewer Note: If more than once, record age when each surgery occurred.)

V0AAG1L	<input type="text"/> <input type="text"/> years old	VOL_ARTYR	
V0AAG2L	<input type="text"/> <input type="text"/> years old	<input type="radio"/> Don't know	V0ADKL
V0AAG3L	<input type="text"/> <input type="text"/> years old		

b. Was this arthroscopy surgery to repair an injury?
VOAINJL **1** Yes **0** No **8** Don't know

33 Did you ever have a meniscectomy (where they repaired or cut away a torn meniscus or cartilage) in your left knee?
VOMENL **1** Yes **0** No **8** Don't know/Refused

a. How old were you when you had this meniscectomy surgery?
(Interviewer Note: If more than once, record age when each surgery occurred.)

V0MAG1L	<input type="text"/> <input type="text"/> years old	VOL_MENYR	
V0MAG2L	<input type="text"/> <input type="text"/> years old	<input type="radio"/> Don't know	V0MDKL
V0MAG3L	<input type="text"/> <input type="text"/> years old		

b. Was this meniscectomy surgery to repair an injury?
VOMINJL **1** Yes **0** No **8** Don't know

Knee Injury and/or Surgery (continued)

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



34 Did you ever have a ligament repair in your left knee?
V0LIGL 1 Yes 0 No 8 Don't know/Refused

a. How old were you when you had this ligament surgery?
(Interviewer Note: If more than once, record age when each surgery occurred.)

V0LAG1L	<input type="text"/> <input type="text"/> years old	VOL_LIGYR	
V0LAG2L	<input type="text"/> <input type="text"/> years old	<input type="radio"/> Don't know	V0LDKL
V0LAG3L	<input type="text"/> <input type="text"/> years old		

b. Was this surgery to repair an injury? **V0LINJL**
 1 Yes 0 No 8 Don't know

35 Did you have another kind of surgery in your left knee?
V0SOTHL 1 Yes 0 No 8 Don't know/Refused

a. What kind of surgery was this? _____
 Don't know **V0SDK1L**

b. How old were you when you had this surgery?
(Interviewer Note: If more than once, record age when each surgery occurred.)

V0SAG1L	<input type="text"/> <input type="text"/> years old	VOL_OTHYR	
V0SAG2L	<input type="text"/> <input type="text"/> years old	<input type="radio"/> Don't know	V0SDKL
V0SAG3L	<input type="text"/> <input type="text"/> years old		

c. Was this surgery to repair an injury? **V0SINJL**
 1 Yes 0 No 8 Don't know

Hip Pain

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



The next few questions are about your hip joints.

Right Hip

First I'll ask you about your right hip.

- 36** 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.
(REQUIRED - Show Card #17.)

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

VOHPN30R **1** Yes **0** No **8** Don't know

36a During the past 30 days, have you had pain, aching, or stiffness in your right hip on most days?

Where is this pain, aching, or stiffness located?
(REQUIRED - Show Card #17. Please mark all that apply.)

VOGRINR 1 Groin/inside leg near hip

VOOTLGR 2 Outside of leg near hip

VOFRLGR 3 Front of leg near hip **1 = YES**

VOBUTTR 4 Buttocks

VOLWBKR 5 Lower back

VOPNDKR Don't know

Interviewer Note: Record that participant has right hip pain on the Knee and Hip Exam form (page 19 in the Clinic Visit Workbook).

Hip Pain

(continued)

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



Left Hip

Now I'll ask you about your left hip.

- 37** 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.
(REQUIRED - Show Card #17.)

VOANYL

1 Yes

0 No

8 Don't know/Refused

VOHPN30L

- 37a** 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

Where is this pain, aching, or stiffness located?

(REQUIRED - Show Card #17. Please mark all that apply.)

VOGRINL 1 Groin/inside leg near hip

V00TLGL 2 Outside of leg near hip

V0FRLGL 3 Front of leg near hip **1 = YES**

V0BUTTLL 4 Buttocks

V0LWBKL 5 Lower back

V0PNDKLL Don't know

Interviewer Note: Record that participant has left hip pain on the Knee and Hip Exam form (page 19 in the Clinic Visit Workbook).

Hip Surgery

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



38 Have you ever had a total hip replacement, where all or part of the joint was replaced?

V0THR

Yes

No

Don't know/Refused

Go to Question #41.

39 Did you have your right hip replaced?

V0R_THR *

1 Yes

0 No

Why was your right hip replaced?
(Interviewer Note: Please mark all that apply.)

V0HFXR Hip fracture

V0HOAR Osteoarthritis or degenerative arthritis **1 = YES**

V0HOTR Other *(Please specify: _____)*

V0HDKR Don't know

Interviewer Note: Record that participant has right hip replaced on the Knee and Hip Exam form (page 19 in the Clinic Visit Workbook).

40 Did you have your left hip replaced?

V0L_THR *

1 Yes

0 No

Why was your left hip replaced?
(Interviewer Note: Please mark all that apply.)

V0HFXL Hip fracture

V0HOAL Osteoarthritis or degenerative arthritis **1 = YES**

V0HOTL Other *(Please specify: _____)*

V0HDKL Don't know

Interviewer Note: Record that participant has left hip replaced on the Knee and Hip Exam form (page 19 in the Clinic Visit Workbook).

* Variable is derived from self-report and radiographic adjudication.



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"/>
Office Use Only	

Shoe Heel Height

1½ inch Heel Shoes

(Interviewer Note: Show women the woman's 1½ inch heel shoe, and show men the man's 1½ inch heel shoe.)

- 41 This is a shoe with a one and a half-inch heel. During the past 30 days, have you worn shoes with heels this high or higher?

V0IN15 ¹ Yes ⁰ No ⁸ Don't know/Refused

How many days did you wear this type of shoe during the past 30 days?

<input type="text"/> <input type="text"/>	V0DAY15 Number of days	V0DK15 <input type="radio"/> Don't know
---	---------------------------	--

2 inch Heel Shoes

(Interviewer Note: Show women the woman's two-inch heel shoe, and show men the man's two inch heel shoe.)

- 42 This is a shoe with a two-inch heel. During the past 30 days, have you worn shoes with heels this high or higher?

V0IN20 ¹ Yes ⁰ No ⁸ Don't know/Refused

How many days did you wear this type of shoe during the past 30 days?

<input type="text"/> <input type="text"/>	V0DAY20 Number of days	V0DK20 <input type="radio"/> Don't know
---	---------------------------	--

- 43 Have you ever regularly worn shoes with heels this high or higher?

V0REG20 ¹ Yes ⁰ No ⁸ Don't know/Refused

Go to Question #54 on page 22.

Shoe Heel Height (continued)

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"/>
Office Use Only	



- 44) When you were in your twenties, did you wear shoes with heels this high or higher?
- V0TW20 Yes No Don't know/Refused

How often did you wear this type of shoe in your twenties?
(Interviewer Note: **REQUIRED - Show Card #3.**)

V0TW20F

All the time

Most of the time

Some of the time

A little of the time

Don't know

- 45) When you were in your thirties, did you wear shoes with heels this high or higher?
- V0TR20 Yes No Don't know/Refused

How often did you wear this type of shoe in your thirties?
(Interviewer Note: **REQUIRED - Show Card #3.**)

V0TR20F

All the time

Most of the time

Some of the time

A little of the time

Don't know

- 46) When you were in your forties, did you wear shoes with heels this high or higher?
- V0FR20 Yes No Don't know/Refused

How often did you wear this type of shoe in your forties?
(Interviewer Note: **REQUIRED - Show Card #3.**)

V0FR20F

All the time

Most of the time

Some of the time

A little of the time

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"/>
Office Use Only	

Shoe Heel Height (continued)

47 When you were in your fifties, did you wear shoes with heels this high or higher?

V0FF20 ¹ Yes ⁰ No ⁸ Don't know/Refused

How often did you wear this type of shoe in your fifties?
(Interviewer Note: **REQUIRED - Show Card #3.**)

- V0FF20F
- ¹ All the time
 - ² Most of the time
 - ³ Some of the time
 - ⁴ A little of the time
 - ⁸ Don't know

3-inch Heel Shoes

Interviewer Note:

- **Men participants:** Go to the Question #54 page 22.
- **Women participants:** Show women the woman's three-inch heel shoe sample.

48 This is a shoe with a three-inch heel. During the past 30 days, have you worn shoes with heels this high or higher?

V0IN30 ¹ Yes ⁰ No ⁸ Don't know/Refused

How many days did you wear this type of shoe during the past 30 days?

V0DAY30 V0DK30
Number of days Don't know

49 Have you ever regularly worn shoes with heels this high or higher?

V0REG30 ¹ Yes ⁰ No ⁸ Don't know/Refused

Go to the Question #54 page 22.

Shoe Heel Height (continued)

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"/>
Office Use Only	



50) When you were in your twenties, did you wear shoes with heels this high or higher?

V0TW30 ¹ Yes ⁰ No ⁸ Don't know/Refused

How often did you wear this type of shoe in your twenties?
(Interviewer Note: REQUIRED - Show Card #3.)

V0TW30F

¹ All the time
² Most of the time
³ Some of the time
⁴ A little of the time
⁸ Don't know

51) When you were in your thirties, did you wear shoes with heels this high or higher?

V0TR30 ¹ Yes ⁰ No ⁸ Don't know/Refused

How often did you wear this type of shoe in your thirties?
(Interviewer Note: REQUIRED - Show Card #3.)

V0TR30F

¹ All the time
² Most of the time
³ Some of the time
⁴ A little of the time
⁸ Don't know

52) When you were in your forties, did you wear shoes with heels this high or higher?

V0FR30 ¹ Yes ⁰ No ⁸ Don't know/Refused

How often did you wear this type of shoe in your forties?
(Interviewer Note: REQUIRED - Show Card #3.)

V0FR30F

¹ All the time
² Most of the time
³ Some of the time
⁴ A little of the time
⁸ Don't know

Shoe Heel Height (continued) and Medication Use Interview

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"/>
Office Use Only	



53) When you were in your fifties, did you wear shoes with heels this high or higher?
V0FF30 Yes No Don't know/Refused

How often did you wear this type of shoe in your fifties?
(REQUIRED - Show Card #18.)

All the time
 Most of the time
V0FF30F Some of the time
 A little of the time
 Don't know

Medication Use Interview

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

a) Vitamin E
 Yes
V0VITE No

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

Less than 100 IU
 100 to 250 IU
V0VITED 300 to 500 IU
 600 IU or more
 Don't know

b) Vitamin C
 Yes
V0VITC No

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

Less than 400 mg
 400 to 700 mg
V0VITCD 750 to 1,250 mg
 1,300 mg or more
 Don't know

Medication Use

Interview (continued)

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"/>
<i>Office Use Only</i>	



55 Have you ever taken a bisphosphonate medication to treat osteoporosis or Paget's disease? This includes the following medications: alendronate (Fosamax), Risedronate (Actonel), etidronate (Didronel), clodronate, ibandronate, Pamidronate (Aredia), or tiludronate (Skelid).
(Interviewer Note: Refer to Card #19 for pronunciation. Do Not Show Card to participants.)

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

↓ ↓ ↓

Go to Question #56.

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

VOBIYR years *(Interviewer Note: Round up year at 6 months. <6 months=0 years, and 6-12 months=1 year, more than 5 = 5 years)*

(Female Participants only)

56 Since menopause, have you taken estrogen or female hormone pills by mouth, such as Premarin, Ogen, or Estrace?

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

↓ ↓ ↓

Go to Question #57.

a. How old were you when you started taking estrogen or female hormone pills? If you are unsure, please make your best guess.

VOHRAGE years old *Note: Round down to nearest ten: e.g., record 20 for 20 to 29; record 30 for 30 to 39; etc.*

b. For how many years did you take estrogen or female hormone pills by mouth every day or nearly every day? If you are unsure, please make your best guess.

VOHRYR years *(Interviewer Note: Round up year at 6 months. <6 months=0 years and 6-12 months=1 year, more than 30 = 30)*

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



Medication Inventory Form

57 Did the participant bring in or identify ALL prescription and over-the-counter medications that they took during the last 30 days?

V0MEDS

All Some None Took None

Total number recorded: <input type="text"/>	<input type="text"/> medications	Arrange for telephone call to complete MIF
---	----------------------------------	--

PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS

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

V0MNUM

Med #

V0FRMCODE

Formulation code:

V0NAME

Name:

V0DUR

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

V0RX

Prescription? Yes No Frequency? As Needed Reg V0FREQ

V0SAME	V0CHONDR	V0FLUOR	V0RALOX
V0ALENDR	V0CSTERD	V0GLCSMN	V0RISEDR
V0ANALGS	V0COXII	V0HYALUR	V0SALICY
V0BISPHOS	V0MSM	V0NARCAN	V0TPTD
V0CALCIT	V0DOXY	V0NSAID	V0VITMND
V0CALCUM	V0ESTROG	V0PROGST	V0OSTEOP

Formulation Codes:

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

Baseline Clinic 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"/>

V0_DATEDIFF

Procedure Checklist

Measurement	Page #	Completed	Partially completed	Participant refused	Not done/ Not applicable
Self-administered Home Questionnaire completed/checked		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self-administered Clinic Questionnaire completed/checked		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clinic Interview Workbook administered		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood Pressure	2	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing Height	3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weight	3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specimen Collection	4	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Laboratory Processing	5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20-meter Walk	6	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chair Stands	7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Isokinetic Strength (Cybex)	9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Leg Length	14	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knee Height	14	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Laxity	15	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Proprioception	16	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hand Examination	18	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knee and Hip Examinations	19	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knee Flexion Contracture	26	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bone Density (DXA)	27	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Completed	Scheduled	Participant refused	Not eligible/ Not applicable
Knee X-ray	28	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OrthOne 1.0 T Knee MRI	29	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.5 T Knee MRI	34	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Yes	Not eligible		Participant refused
Participant eligible for confirmatory joint exam? (See pages 24 and 25.)		<input type="radio"/>	<input type="radio"/>		<input type="radio"/>

Blood Pressure



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	

① What cuff size was used?

V0CUFF Small Regular Large Thigh

② What arm was used to take the blood pressure?

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

V0ARM Right Left

Pulse Obliteration Level: Complete only if using a sphygmomanometer.

③ Palpated Systolic mm Hg

V0LEVEL

+ *

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

Maximal Inflation Level ** mm Hg

(MIL)

V0MIL

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

Was blood pressure measurement terminated because MIL is ≥ 300 mm Hg after second reading?

V0STOP Yes No

④ **V0SBP** Systolic mm Hg

V0DBP Diastolic mm Hg

⑤ Is the participant's blood pressure greater than 199 mm Hg (systolic) or greater than 109 mm Hg (diastolic)?

V0BPGT199 Yes No

Examiner Note: Record that participant's blood pressure is greater than 199 mm Hg (systolic) or greater than 109 mm Hg (diastolic) on the Isokinetic Strength (Cybex) data collection form (page 9, Question # 1 in the Clinic Visit Workbook).

Standing Height

MOST ID #	Acrostic	Date Form Completed																				
<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>									<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>					<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> </table> <div style="display: flex; justify-content: space-around; font-size: small;"> Month / Day / Year </div>								



Measure participant's height without shoes. Use the required breathing technique during each measurement. For all repeat measurements, have the participant step away from the stadiometer, then step back into the measurement position.

① Is the participant standing sideways due to kyphosis?

V0KYPHO

Yes No

V0HT

② Measurement 1

--	--	--	--

 mm

V0HT1

V0WT

③ Measurement 2

--	--	--	--

 mm

V0HT2

V0BMI

④ Difference between Measurement 1 & Measurement 2

--	--

 mm

V0DIFF

⑤ Is the difference between Measurement 1 and Measurement 2 greater than 3 mm?

V0DIFF2

Yes

No

Complete Measurement 3 and Measurement 4 below.

Go to Weight.

⑥ Measurement 3

--	--	--	--

 mm

V0HT3

V0HTSID

⑦ Measurement 4

--	--	--	--

 mm

V0HT4

Staff ID#

--	--	--

Weight

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

V0WGHT

			.		kg
--	--	--	---	--	----

V0WTSID

Staff ID#

--	--	--

Specimen Collection

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

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

a. Date:

 /

Month Day

b. Time:

 :

 am
Hours Minutes pm

c. How many hours has participant fasted?

 Hours

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

7 **Bar Code Label**

Enter ID from Bar Code label:

--	--	--	--

2 Do you bleed or bruise easily?
 Yes No Don't know/Refused

8 Was any blood drawn?
 Yes No

Please describe why not: _____

3 Have you ever been told you have a disorder related to blood clotting or coagulation?
 Yes No Don't know/Refused

Were tubes filled to specified capacity?
(Note: wrap all tubes in foil.)

Tube	Volume	Filled to Capacity
1. EDTA	7mL	<input type="radio"/> Yes <input type="radio"/> No
2. Serum	15mL	<input type="radio"/> Yes <input type="radio"/> No
3. EDTA	7mL	<input type="radio"/> Yes <input type="radio"/> No
4. Serum	15mL	<input type="radio"/> Yes <input type="radio"/> No

4 Have you ever had a shunt or port for kidney dialysis?
 Yes No Don't know/Refused

Which side?
 Right Left Both

Draw blood on left.	Draw blood on right.	Do NOT draw blood.
---------------------	----------------------	--------------------

Time of blood draw:

 :

 am
Hours Minutes pm

5 Have you ever had a radical mastectomy?
(Female participants only.)
 Yes No Don't know/Refused

Which side?
 Right Left Both

Draw blood on left.	Draw blood on right.	Do NOT draw blood.
---------------------	----------------------	--------------------

9 Was any urine collected?
 Yes No

Please describe why not: _____

Time of urine collection:

 :

 am
Hours Minutes pm

6 Have you ever experienced fainting spells while having blood drawn?
 Yes No Don't know/Refused

10 Comments on blood or urine collection:

Laboratory Processing

MOST ID #	Acrostic	Date Form Completed	Staff ID#																
<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> </tr> </table>					<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> </tr> </table>					<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> </tr> </table> <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>					<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> <td style="width: 25%;"> </td> </tr> </table>				

Time at start of processing: <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"> </table> : <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"> </table> <input type="radio"/> am <input type="radio"/> pm Hours Minutes				
Collection Tubes	Cryo #	Vol.	Type	Condition of cryovial (mark only one)
#1 and #3 EDTA plasma				
-supernatant	01	0.5	Y/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-supernatant	02	0.5	Y/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
Ending time of vortexing: <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"> </table> : <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"> </table> <input type="radio"/> am <input type="radio"/> pm Hours Minutes				
-plasma	03	1.0	V/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-plasma	04	1.0	V/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-plasma	05	1.0	V/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-plasma	06	1.0	V/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-plasma	07	1.0	V/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-buffy coat	08	var	W/2.0	<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 processing: <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"> </table> : <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"> </table> <input type="radio"/> am <input type="radio"/> pm Hours Minutes				
#2 and #4 serum				
-serum	09	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	10	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	11	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	12	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	13	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	14	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	15	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	16	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	17	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	18	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	19	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	20	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	21	1.0	R/2.0	<input type="radio"/> OK <input type="radio"/> H <input type="radio"/> P <input type="radio"/> B <input type="radio"/> not filled
-serum	22	1.0	R/2.0	<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 processing: <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"> </table> : <table border="1" style="display: inline-table; width: 40px; height: 20px; vertical-align: middle;"> </table> <input type="radio"/> am <input type="radio"/> pm Hours Minutes				
Urine				
-urine	23	1.5	C/2.0	<input type="radio"/> OK <input type="radio"/> P <input type="radio"/> not filled
-urine	24	1.5	C/2.0	<input type="radio"/> OK <input type="radio"/> P <input type="radio"/> not filled
-urine	25	1.5	C/2.0	<input type="radio"/> OK <input type="radio"/> P <input type="radio"/> not filled

Bar Code Label

Enter ID from Bar Code label:

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Did participant consent to DNA/genetic testing?

Yes No

Do NOT collect buffy coat sample.

BRI use only:
 Received Date: _____
 Time: _____

H=Hemolyzed
 P=Partial
 B=Both
 Y=Yellow
 V=Violet
 W=White
 R=Red
 C=Clear

20-Meter Walk



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

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?"

V0_STEP

"Ready, Go."

V0_WALKT

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

V0STEP1

V0WALKT1

Trial 1

1 Done Steps Second Hundredths/Sec

7 Participant refused

2 Not attempted, unable

3 Attempted, unable to complete

Stop test.
Go to next exam.

V0WALK1

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."

V0STEP2

V0WALKT2

Trial 2

1 Done Steps Second Hundredths/Sec

7 Participant refused

2 Not attempted, unable

3 Attempted, unable to complete

Stop test.
Go to next exam.

V0WALK2

③ Was the participant using a walking aid, such as a cane? ¹ Yes ⁰ No

V0AID

Chair Stands



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	

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!"

<p>① Single Chair Stand VOCHAIR</p> <p>1 <input type="radio"/> Stands without using arms</p> <p>4 <input type="radio"/> Rises using arms</p> <p>7 <input type="radio"/> Participant refused</p> <p>2 <input type="radio"/> Not attempted, unable</p> <p>3 <input type="radio"/> Attempted, unable to stand</p>	→	Go to Repeated Chair Stands on the next page.
	→	Stop test. Go to next exam.
	→	
	→	
	→	

Chair Stands (cont.)

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



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 Trial 1 **V0TR1**

<p>1 <input type="radio"/> Completes 5 stands without using arms</p> <p>4 <input type="radio"/> Rises using arms</p> <p>7 <input type="radio"/> Participant refused</p> <p>2 <input type="radio"/> Not attempted, unable</p> <p>3 <input type="radio"/> Attempted, unable to complete</p>	<div style="display: flex; align-items: center; margin-bottom: 10px;"> <input style="width: 40px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 40px; height: 20px; margin-right: 5px;" type="text"/> . <input style="width: 40px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <div style="margin-left: 20px;">V0CTIME1 Seconds (Time on stopwatch)</div> </div> <div style="border: 1px solid black; padding: 10px; text-align: center; margin-bottom: 10px;"> Stop test. Go to next exam. </div> <div style="display: flex; align-items: center;"> <input style="width: 40px; height: 20px; margin-right: 5px;" type="text"/> <div style="margin-left: 20px;">V0NUM1 Number completed without using arms</div> </div>
---	--

③ "OK. I'd like you to rest a couple of minutes and we will try to do that one more time. Can you do that?"

(Examiner Note: Wait 2 minutes and then repeat the Repeated Chair Stands.)

V0_CTIME

"Ready, Go!"

Trial 2 **V0TR2**

<p>1 <input type="radio"/> Completes 5 stands without using arms</p> <p>4 <input type="radio"/> Rises using arms</p> <p>7 <input type="radio"/> Participant refused</p> <p>2 <input type="radio"/> Not attempted, unable</p> <p>3 <input type="radio"/> Attempted, unable to complete</p>	<div style="display: flex; align-items: center; margin-bottom: 10px;"> <input style="width: 40px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 40px; height: 20px; margin-right: 5px;" type="text"/> . <input style="width: 40px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <div style="margin-left: 20px;">V0CTIME2 Seconds (Time on stopwatch)</div> </div> <div style="border: 1px solid black; padding: 10px; text-align: center; margin-bottom: 10px;"> Stop test. Go to next exam. </div> <div style="display: flex; align-items: center;"> <input style="width: 40px; height: 20px; margin-right: 5px;" type="text"/> <div style="margin-left: 20px;">V0NUM2 Number completed without using arms</div> </div>
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Isokinetic Strength (Cybex)



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

Exclusion Criteria

- ① Is the participant's blood pressure greater than 199 mm Hg (systolic) or greater than 109 mm Hg (diastolic)?

(Examiner Note: Refer to Blood Pressure form, page 2.)

Yes No Don't know/Refused

Do NOT test.
 Go to Question #12 on page 11
 and Question #15 on page 12.

Script: "First I need to ask you a few questions to see if you should do this test."

- ② Has a doctor ever told you that you had an aneurysm in the brain?

Yes No Don't know/Refused

Do NOT test.
 Go to Question #12 on page 11
 and Question #15 on page 12.

- ③ Has a doctor told you that you had a cerebral hemorrhage (bleeding in the brain) in the last six months?

Yes No Don't know/Refused

Do NOT test.
 Go to Question #12 on page 11
 and Question #15 on page 12.

- ④ Have you had either of your knees replaced in the past 3 months?

Yes No Don't know/Refused

Which knee was replaced?

Right

Left

Both knees

If no other exclusions
test left leg.

If no other exclusions
test right leg.

Do NOT test.
 Go to Question #12 on page 11
 and Question #15 on page 12.

Isokinetic Strength (cont.)



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

5 Have you had either of your hips replaced in the past 3 months?

Yes No Don't know/Refused

Which hip was replaced?

Right Left Both hips

If no other exclusions
test left leg.

If no other exclusions
test right leg.

Do NOT test.
Go to Question #12 on page 11
and Question #15 on page 12.

6 Within the past 3 months, have you had back surgery?

Yes No Don't know/Refused

Do NOT test.
Go to Question #12 on page 11
and Question #15 on page 12.

7 Within the past 6 weeks, have you had a heart attack?

Yes No Don't know/Refused

Do NOT test.
Go to Question #12 on page 11
and Question #15 on page 12.

8 Within the past 6 weeks, have you had cataract surgery?

Yes No Don't know/Refused

Do NOT test.
Go to Question #12 on page 11
and Question #15 on page 12.

9 Do you have a hernia in your groin that has not been operated on?

Yes No Don't know/Refused

Do NOT test.
Go to Question #12 on page 11
and Question #15 on page 12.

Isokinetic Strength (cont.)



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

10 Manual Positioning Settings

	a. Chair Back Angle	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> °	e. Dynamometer Height (range 0-10)	<input style="width: 20px; height: 20px;" type="text"/>	V0SETE
V0SETB	b. Chair Seat Fore/Aft Position (range 0-8)	<input style="width: 20px; height: 20px;" type="text"/>	f. Knee/Hip Adapter (range 15-38)	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	V0SETF
V0SETC	c. Chair Back Translation (range A-P)	<input style="width: 20px; height: 20px;" type="text"/>	g. Inner Tube (range 27-41)	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	V0SETG
	d. Dynamometer Tilt	<input style="width: 20px; height: 20px;" type="text"/> °	h. Outer Tube (range A-K)	<input style="width: 20px; height: 20px;" type="text"/>	V0SETH

11 Record MaxGET for left leg. V0MGETL

12 Was the flexion/extension test performed on the left leg?
V0TESTL Yes No

V0DONEL

a. Was the entire set completed?
 Yes No

How many extension/flexion sets were completed?

V0NUML

b. What were the highest four torques?

Flexion	Extension
<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Nm	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Nm
<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Nm	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Nm
<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Nm	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Nm
<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Nm	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Nm

Why wasn't the test done?
(Examiner Note: Mark all that apply.)

Participant excluded based on eligibility criteria V0EXCLL
 Participant refused V0REFUL
 Stopped test due to participant discomfort or exclusion V0STOPL
 Other **(Please specify: _____)** V0COTHL

V0FLX1L
V0FLX2L
V0FLX3L
V0FLX4L

V0EXT1L
V0EXT2L
V0EXT3L
V0EXT4L

V0L_FLXMAX

V0L_EXTMAX

V0L_HSQ

Isokinetic Strength (cont.)



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

13 "Did you have any knee pain during this test?"
V0PAINL 1 Yes 0 No

a. Was it mild, moderate, or severe?

1 Mild **V0MILDL**

2 Moderate

3 Severe

8 Don't know

b. Did this pain prevent you from pushing or pulling as hard as you can?

1 Yes **V0PUSHL**

0 No

8 Don't know

14 Record MaxGET for right leg. **V0MGETR**

15 Was the flexion/extension test performed on the right leg?
V0TESTR 1 Yes 0 No

a. Was the entire set completed?
 1 Yes 0 No

How many extension/flexion sets were completed? **V0NUMR**

b. What were the highest four torques?

Flexion	Extension
<input type="text"/> <input type="text"/> <input type="text"/> Nm	<input type="text"/> <input type="text"/> <input type="text"/> Nm
<input type="text"/> <input type="text"/> <input type="text"/> Nm	<input type="text"/> <input type="text"/> <input type="text"/> Nm
<input type="text"/> <input type="text"/> <input type="text"/> Nm	<input type="text"/> <input type="text"/> <input type="text"/> Nm
<input type="text"/> <input type="text"/> <input type="text"/> Nm	<input type="text"/> <input type="text"/> <input type="text"/> Nm

Why wasn't the test done?
(Examiner Note: Mark all that apply.)

Participant excluded based on eligibility criteria **V0EXCLR**

Participant refused **V0REFUR**

Stopped test due to participant discomfort or exclusion **V0STOPR**

Other (*Please specify:* _____) **V0COTHR**

V0FLX1R

V0FLX2R

V0FLX3R

V0FLX4R

V0EXT1R

V0EXT2R

V0EXT3R

V0EXT4R

V0R_FLXMAX

V0R_EXTMAX

V0R_HSQ

Isokinetic Strength (cont.)



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

①⑥ "Did you have any knee pain during this test?"

1 Yes
0 No
V0PAINR

a. Was it mild, moderate, or severe?

1 Mild
2 Moderate
3 Severe
8 Don't know
V0MILDR

b. Did this pain prevent you from pushing or pulling as hard as you can?

1 Yes
0 No
8 Don't know
V0PUSHR

Leg Length



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

① Has the participant had abdominal surgery that left the belly button off the mid-line of the body?

V0BELLY

Yes No

Do not measure either leg. Go to next exam.

② Has the participant had an above- or below-the-knee amputation?

V0AMP

Yes No

Which leg was amputated?

Right Left Both

Measure left leg.

Measure right leg.

Do not measure either leg.

③ Right leg length:

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

V0LLR

④ Left leg length:

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

V0LLL

V0LLSID

Staff ID#

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

Knee Height

Right leg is measured unless the left leg is obviously longer than the right leg or if the right leg cannot be measured for some other reason (e.g., cast, sores, etc.).

① Which leg is being measured?

¹ Right ² Left

V0KHLEG

② Measurement 1

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

V0KHT1

③ Measurement 2

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

V0KHT2

④ Difference between Measurement 1 & Measurement 2

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

V0KDIFF

⑤ Is the difference between Measurement 1 and Measurement 2 greater than .4 cm?

V0DIFF4

Yes

No

Complete Measurement 3 and Measurement 4 below.

Go to next exam.

V0KHT

⑥ Measurement 3

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

V0KHT3

⑦ Measurement 4

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

V0KHT4

V0BELLY

Staff ID#

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

Laxity

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"/>
Office Use Only		Month Day Year	

Script: "This is a test to see how much side to side motion you have at each of your knees. You will be sitting on this bench and I will be moving your knee gently side to side (**can demonstrate the movement with your hands as you say this**). Only a small amount of movement occurs in this direction at the knee. This bench allows us to measure it carefully. This test is not painful."

Participant sits on their left side of the bench with their back leaning against the wall. Ask participant to bring their right leg into the thigh and ankle cushioned restraints. The superior pole of the patella should be level with the bottom edge of the thigh restraint. The tibial tubercle should be pointing straight up.

After the Participant is positioned ask: "Are you comfortable?"

If Participant responds "yes," then say, "Your only job for this test is to keep your muscles relaxed and loose."

① Right knee:

Starting position:	<input type="text"/> <input type="text"/> °	Script: "I'm now going to check the movement for this knee in the other direction."
	<u>Lateral</u>	<u>Medial</u>
Trial 1	<input type="text"/> <input type="text"/> °	Trial 1 <input type="text"/> <input type="text"/> °
Trial 2	<input type="text"/> <input type="text"/> °	Trial 2 <input type="text"/> <input type="text"/> °
Trial 3	<input type="text"/> <input type="text"/> °	Trial 3 <input type="text"/> <input type="text"/> °
Trial 4	<input type="text"/> <input type="text"/> °	Trial 4 <input type="text"/> <input type="text"/> °
		VOR_LAXLAT
		VOR_LAXMED

Script: "I'm now going to check the movement in the same two directions in the left knee. Remember, your job is to keep your knee as relaxed as you can."

② Left knee:

Starting position:	<input type="text"/> <input type="text"/> °	Script: "I'm now going to check the movement for this knee in the other direction."
	<u>Lateral</u>	<u>Medial</u>
Trial 1	<input type="text"/> <input type="text"/> °	Trial 1 <input type="text"/> <input type="text"/> °
Trial 2	<input type="text"/> <input type="text"/> °	Trial 2 <input type="text"/> <input type="text"/> °
Trial 3	<input type="text"/> <input type="text"/> °	Trial 3 <input type="text"/> <input type="text"/> °
Trial 4	<input type="text"/> <input type="text"/> °	Trial 4 <input type="text"/> <input type="text"/> °
		VOL_LAXLAT
		VOL_LAXMED

Proprioception



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

① Which foot do you or did you prefer to kick a ball with?

V0FOOT

1
 Right foot

Attach electrogoniometer to right leg.

2
 Left foot

Attach electrogoniometer to left leg.

8
 Don't know/Refused

Attach electrogoniometer to right leg.

② Angle from leg dangling (0°) to full knee extension: °

V0ANGLE

③ Was additional tape used to attach the endblocks?

V0TAPE

Yes

No

Refused

Proprioception

(cont.)

MOST ID #	Acrostatic	Date Form Completed	Staff ID#																								
<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table> <p style="text-align: center; font-size: small;">Office Use Only</p>									<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>					<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table> <p style="text-align: center; font-size: small;">Month / Day / Year</p>									<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>				

④ Which leg is being tested?

Right leg
0

Left leg
1

V0LE

Practice Sessions	Test Angle (5 sec)		Reproduced Angle (3 sec)		Refused	Not Attempted/Unable	Attempted, unable to complete
	Angle held longest (OR if much drift: record low value of range.)	(If much drift: record high value of range.)	Angle held longest (OR if much drift: record low value of range.)	(If much drift: record high value of range.)			
1 (30-40°)					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2 (15-25°)					<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Test Sessions							
1 (35-45°)	V0T11 °	V0T12 °	V0T13 °	V0T14 °	<input type="radio"/>	V0NOT1	<input type="radio"/>
2 (15-25°)	V0T21 °	V0T22 °	V0T23 °	V0T24 °	<input type="radio"/>	V0NOT2	<input type="radio"/>
3 (>45°)	V0T31 °	V0T32 °	V0T33 °	V0T34 °	<input type="radio"/>	V0NOT3	<input type="radio"/>
4 (5-15°)	V0T41 °	V0T42 °	V0T43 °	V0T44 °	<input type="radio"/>	V0NOT4	<input type="radio"/>
5 (25-35°)	V0T51 °	V0T52 °	V0T53 °	V0T54 °	<input type="radio"/>	V0NOT5	<input type="radio"/>
6 (15-25°)	V0T61 °	V0T62 °	V0T63 °	V0T64 °	<input type="radio"/>	V0NOT6	<input type="radio"/>
7 (35-45°)	V0T71 °	V0T72 °	V0T73 °	V0T74 °	<input type="radio"/>	V0NOT7	<input type="radio"/>
8 (5-15°)	V0T81 °	V0T82 °	V0T83 °	V0T84 °	<input type="radio"/>	V0NOT8	<input type="radio"/>
9 (> 45°)	V0T91 °	V0T92 °	V0T93 °	V0T94 °	<input type="radio"/>	V0NOT9	<input type="radio"/>
10 (25-35°)	V0T101 °	V0T102 °	V0T103 °	V0T104 °	<input type="radio"/>	V0NOT10	<input type="radio"/>

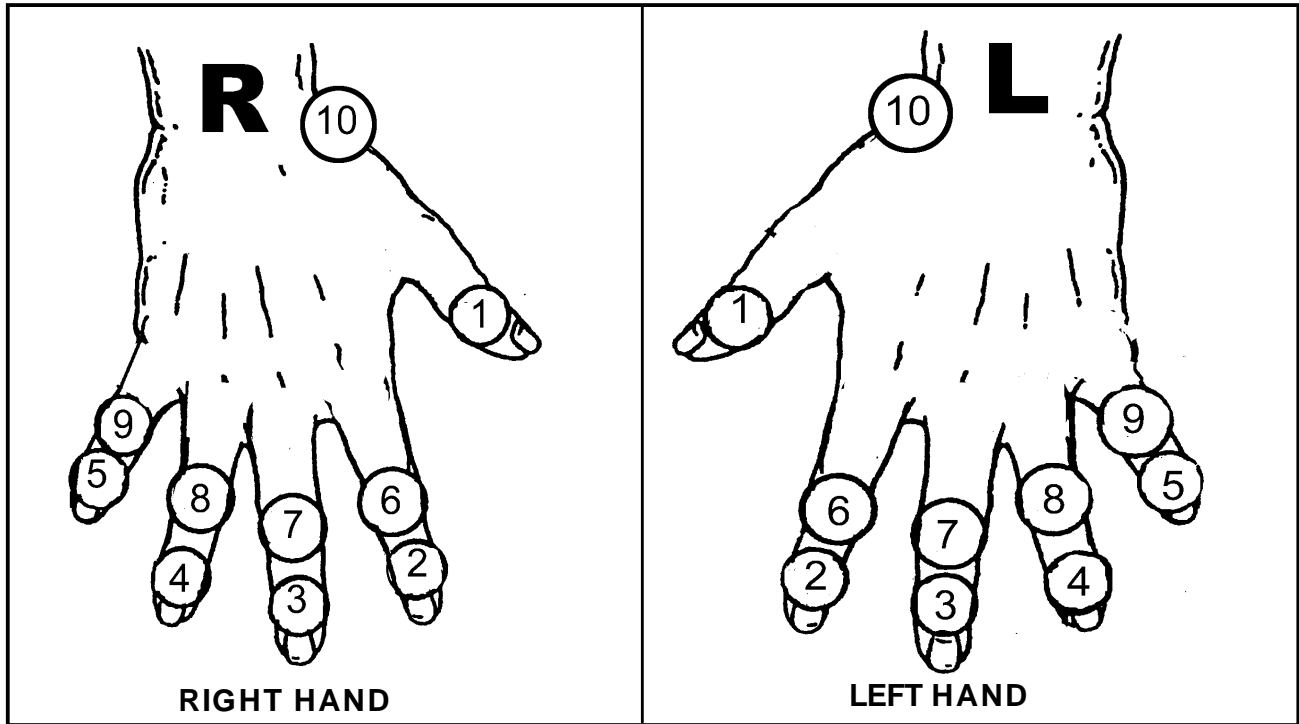
V0PROP_MEAN

V0PROP_SD

Hand Examination



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	



V0NORH ¹ Right hand was not examined

V0NOLH ¹ Left hand was not examined

V0R_HJOA

Right Hand

Left Hand

V0L_HJOA

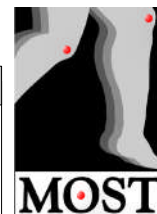
Right Joint/Hand	Normal	Bony enlargement	Uncertain *	Unable to examine	Left Joint/Hand	Normal	Bony enlargement	Uncertain *	Unable to examine
1 V0H1R	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁸ <input type="radio"/>	1 V0H1L	¹ <input type="radio"/>	² <input type="radio"/>	³ <input type="radio"/>	⁸ <input type="radio"/>
2 V0H2R	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2 V0H2L	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3 V0H3R	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	3 V0H3L	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4 V0H4R	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	4 V0H4L	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5 V0H5R	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	5 V0H5L	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6 V0H6R	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	6 V0H6L	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7 V0H7R	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	7 V0H7L	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8 V0H8R	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	8 V0H8L	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9 V0H9R	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	9 V0H9L	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10 V0H10R	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	10 V0H10L	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**If uncertain on two or more joints per hand, obtain consensus with another examiner for all joints on that hand.*

V0R_HJMIS

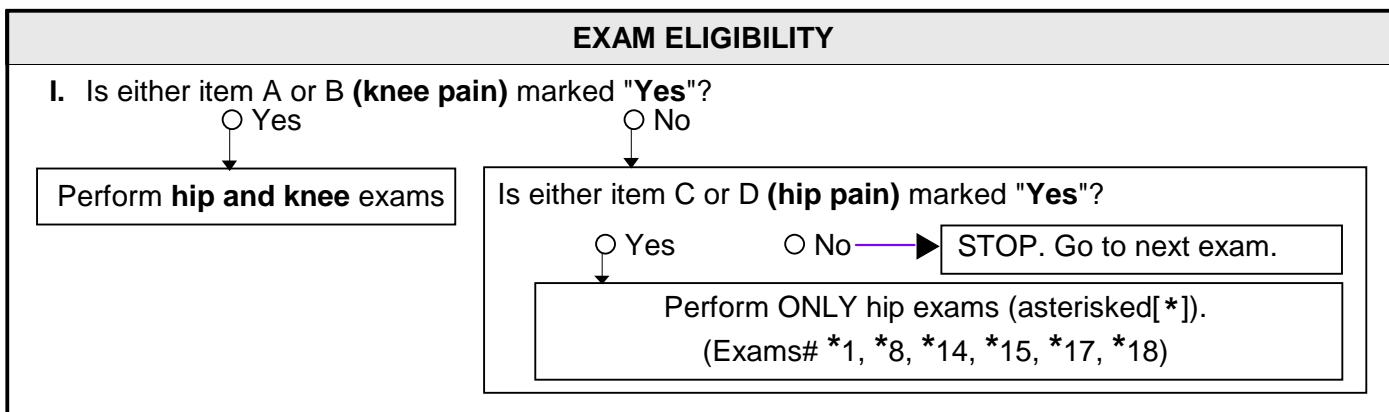
V0L_HJMIS

Knee and Hip Examinations



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

BOX 1. SELF-REPORT KNEE and HIP PAIN <i>(Examiner Note: Refer to Clinic Interview Workbook. Please mark ALL that apply.)</i>			
A. Clinic Interview Question # 13a. Right knee	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
B. Clinic Interview Question # 15a. Left knee pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
C. Clinic Interview Question # 36a. Right hip pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
D. Clinic Interview Question # 37a. Left hip pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
E. Clinic Interview Question # 39. Right hip replaced	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
F. Clinic Interview Question # 40. Left hip replaced	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused



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

Exam	Exam done? "Is this tender or painful?"
<p>* ① Trochanteric bursitis Has the participant had a <u>right</u> hip replacement? <i>(Refer to Box 1, letter E above. Mark "Yes" if "Yes" on E. Mark "No" otherwise.)</i></p> <p style="text-align: center;"><input type="radio"/> No <input type="radio"/> Yes</p> <p style="text-align: center;">↓</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">Do NOT perform <u>right</u> trochanteric bursitis exam.</div>	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No V0PN1R</p> <p>7 <input type="radio"/> Refused 8 <input type="radio"/> Not done</p>
<p>② Iliotibial band</p>	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No V0PN2R</p> <p>7 <input type="radio"/> Refused 8 <input type="radio"/> Not done</p>

Knee and Hip Examinations (cont.)



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

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

Exam	Exam done? "Is this tender or painful?"
③ Anserine bursa	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 7 Refused <input type="radio"/> 8 Not done VOPN3R
④ Medial tibio-femoral joint line	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 7 Refused <input type="radio"/> 8 Not done VOPN4R
⑤ Lateral tibio-femoral joint line	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 7 Refused <input type="radio"/> 8 Not done VOPN5R
⑥ Patellar tenderness	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 7 Refused <input type="radio"/> 8 Not done VOPN6R
⑦ Medial knee fat pad tenderness	<input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 7 Refused <input type="radio"/> 8 Not done VOPN7R
*⑧ Hip internal rotation <u>pain</u> <input type="radio"/> No <input type="radio"/> Yes Has the participant had a <u>right</u> hip replacement? <i>(Refer to Box 1, letter E on page 19. Mark "Yes" if "Yes" on E. Mark "No" otherwise.)</i>	VOPN8R <input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 7 Refused <input type="radio"/> 8 Not done Where does it hurt? <i>(Show Card # 20. Mark <u>all</u> that apply.)</i>
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 20px;"> Do NOT perform <u>right</u> hip pain exam. </div>	<div style="border: 1px solid black; padding: 5px; margin-left: 20px;"> <input type="radio"/> 1 Groin/inside leg near hip <input type="radio"/> 2 Outside of leg near hip <input type="radio"/> 3 Front of leg near hip <input type="radio"/> 4 Buttocks <input type="radio"/> 5 Lower back 1 = YES <input type="radio"/> Don't know </div>

Knee and Hip Examinations (cont.)



MOST ID #	Acrostic	Date Form Completed	Staff ID#
<div style="display: flex; justify-content: space-around;"> <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> <p style="text-align: center; font-size: small;">Office Use Only</p>	<div style="display: flex; justify-content: space-around;"> <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-around;"> <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> <p style="text-align: center; font-size: small;">Month Day Year</p>	<div style="display: flex; justify-content: space-around;"> <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>

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

Exam	Exam done? "Is this tender or painful?"
<p>9 Anserine bursa</p>	<p><input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 7 Refused <input type="radio"/> 8 Not done</p> <p style="color: blue;">V0PN9L</p>
<p>10 Medial tibio-femoral joint line</p>	<p><input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 7 Refused <input type="radio"/> 8 Not done</p> <p style="color: blue;">V0PN10L</p>
<p>11 Lateral tibio-femoral joint line</p>	<p><input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 7 Refused <input type="radio"/> 8 Not done</p> <p style="color: blue;">V0PN11L</p>
<p>12 Patellar tenderness</p>	<p><input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 7 Refused <input type="radio"/> 8 Not done</p> <p style="color: blue;">V0PN12L</p>
<p>13 Medial knee fat pad tenderness</p>	<p><input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 7 Refused <input type="radio"/> 8 Not done</p> <p style="color: blue;">V0PN13L</p>
<p>*14 Hip internal rotation <u>pain</u> <input type="radio"/> No <input type="radio"/> Yes</p> <p>Has the participant had a <u>left</u> hip replacement? <i>(Refer to Box 1, letter F on page 19. Mark "Yes" if "Yes" on F. Mark "No" otherwise.)</i></p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 100px;"> <p style="text-align: center;">Do NOT perform <u>left</u> hip pain exam.</p> </div>	<p><input type="radio"/> 1 Yes <input type="radio"/> 0 No <input type="radio"/> 8 Not done</p> <p style="color: blue;">V0PN14L</p> <div style="border: 1px solid black; padding: 5px;"> <p>Where does it hurt? <i>(Show Card # 20, Mark <u>all</u> that apply.)</i></p> <p><input type="radio"/> 1 Groin/inside leg near hip</p> <p><input type="radio"/> 2 Outside of leg near hip</p> <p><input type="radio"/> 3 Front of leg near hip</p> <p><input type="radio"/> 4 Buttocks</p> <p><input type="radio"/> 5 Lower back 1 = YES</p> <p><input type="radio"/> Don't know</p> </div>

Knee and Hip Examinations (cont.)

MOST ID #	Acrostic	Date Form Completed	Staff ID#																									
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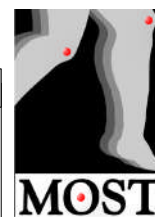
Left-side exams: Participant is lying on their right side.

Exam	Exam done? "Is this tender or painful?"
<p>*15 Trochanteric bursitis <input type="radio"/> No <input type="radio"/> Yes</p> <p>Has the participant had a <u>left</u> hip replacement? (Refer to Box 1, letter F on page 19.) Mark "Yes" if "Yes" on F. Mark "No" otherwise.)</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 100px;"> Do NOT perform <u>left</u> trochanteric bursitis exam. </div>	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done</p> <p style="color: blue; font-weight: bold; font-size: 1.2em;">VOPN15L</p>
<p>*16 Iliotibial band</p>	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done</p> <p style="color: blue; font-weight: bold; font-size: 1.2em;">VOPN16L</p>

Hip internal rotation exams: Participant is sitting.

Exam	Exam done?	How many degrees was the limit of motion?			
<p>*17 Right hip internal rotation <input type="radio"/> No <input type="radio"/> Yes</p> <p>Has the participant had a <u>right</u> hip replacement? (Refer to Box 1, letter E on page 19.) Mark "Yes" if "Yes" on E. Mark "No" otherwise.)</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 100px;"> Do NOT perform <u>right</u> hip exam. </div>	<p><input type="radio"/> Yes <input type="radio"/> No</p>	<p><table border="1" style="width: 30px; height: 20px; display: inline-table;"> <tr><td style="width: 10px;"> </td><td style="width: 10px;"> </td><td style="width: 10px;"> </td></tr> </table> degrees</p> <p style="color: blue; font-weight: bold; font-size: 1.2em;">VOLOMR</p>			
<p>*18 Left hip internal rotation <input type="radio"/> No <input type="radio"/> Yes</p> <p>Has the participant had a <u>left</u> hip replacement? (Refer to Box 1, letter F on page 19.) Mark "Yes" if "Yes" on F. Mark "No" otherwise.)</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: 100px;"> Do NOT perform <u>left</u> hip exam. </div>	<p><input type="radio"/> Yes <input type="radio"/> No</p>	<p><table border="1" style="width: 30px; height: 20px; display: inline-table;"> <tr><td style="width: 10px;"> </td><td style="width: 10px;"> </td><td style="width: 10px;"> </td></tr> </table> degrees</p> <p style="color: blue; font-weight: bold; font-size: 1.2em;">VOLOML</p>			

Knee and Hip Examinations (cont.)



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

Tenderpoint exams: *Participant is sitting.*

19 Was pain present during either the right or left medial knee fat pad exams # 7 and/or # 13? **VOEX19**

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

Exam	Exam done? "Is this tender or painful?"
a. Right elbow tenderpoint	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Refused <input type="radio"/> Not done VOPN19A
b. Left elbow tenderpoint	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Refused <input type="radio"/> Not done VOPN19B
c. Right trapezius tenderpoint	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Refused <input type="radio"/> Not done VOPN19C
d. Left trapezius tenderpoint	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Refused <input type="radio"/> Not done VOPN19D

Knee and Hip Examinations (cont.)

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



Eligibility for Physician Confirmatory Examination

I. RIGHT hip exam

Are one or more of the following conditions met?

- *Exam #8 Pain location 1 or 3 are marked, or
- *Exam #17 degree of motion is less than 105 degrees.

Yes No → Go to II.

Is item A (**right knee pain**) or C (**right hip pain**) in BOX 1 (p19) marked "Yes"?

Yes No → Go to II.

Refer for physician exam. **STOP.**

II. LEFT hip exam

Are one or more of the following conditions met?

- *Exam #14 Pain location 1 or 3 are marked, or
- *Exam #18 degree of motion is less than 105 degrees.

Yes No → Go to III.

Is item B (**left knee pain**) or D (**left hip pain**) in BOX 1 (p19) marked "Yes"?

Yes No → Go to III.

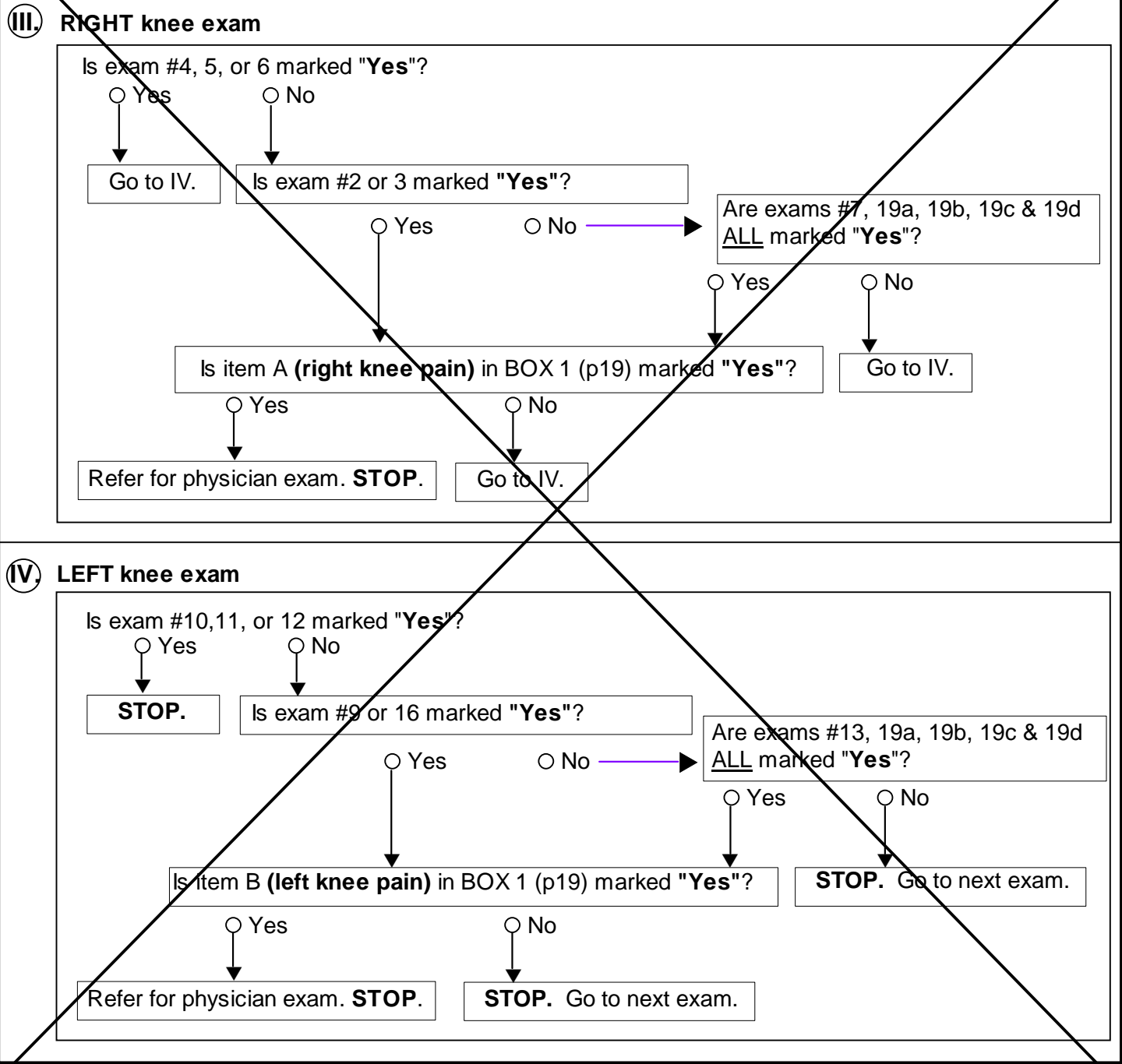
Refer for physician exam. **STOP.**

Knee and Hip Examinations (cont.)



MOST ID #	Acrostic	Date Form Completed	Staff ID#
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Eligibility for Physician Confirmatory Examination



Knee Flexion Contracture

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

Examiner Note: Participant is lying supine on DXA table with skin in front and behind knees exposed.

Right knee

Script: "Please straighten out your right knee as much as you can."

- ① Able to touch back of right knee to the table.

1 Yes 0 No **V0KFLX1R**

Does the ruler touch the back of the right knee?

1 Yes 0 No **V0KFLX2R**

Left knee

Script: "Please straighten out your left knee as much as you can."

- ② Able to touch back of left knee to the table.

1 Yes 0 No **V0KFLX1L**

Does the ruler touch the back of the left knee?

1 Yes 0 No **V0KFLX2L**

DXA Bone Density



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

1 Have you ever had a hip surgery for joint replacement or fracture repair?
 Yes No Refused

↓

Scan **right** hip

↓

On which side did you have hip surgery?
 Right Left Both

↓ ↓ ↓

Scan **left** hip

Scan **right** hip

Do NOT scan either hip

2 Do you have any metal objects or implants in your body, such as a pacemaker, staples, screws, plates, breast implants etc.?
 Yes No Don't Know Refused

↓

a. Flag scan for review by DXA Reading Center.
 b. Indicate the location of the artifacts. (Sub regions are those defined by the whole body scan analysis, e.g., left breast implant is in left ribs, left hip replacement is in pelvis and left leg.)

Sub regions	Hardware	Other Artifacts
i. Head	<input type="radio"/>	<input type="radio"/>
ii. Left arm	<input type="radio"/>	<input type="radio"/>
iii. Right arm	<input type="radio"/>	<input type="radio"/>
iv. Left ribs	<input type="radio"/>	<input type="radio"/>
v. Right ribs	<input type="radio"/>	<input type="radio"/>
vi. Thoracic spine	<input type="radio"/>	<input type="radio"/>
vii. Lumbar spine	<input type="radio"/>	<input type="radio"/>
viii. Pelvis	<input type="radio"/>	<input type="radio"/>
ix. Left Leg	<input type="radio"/>	<input type="radio"/>
x. Right leg	<input type="radio"/>	<input type="radio"/>

3 Have you had any of the following in the past ten days?

	Yes	No
a. Barium enema	<input type="radio"/> *	<input type="radio"/>
b. Upper GI X-ray series	<input type="radio"/> *	<input type="radio"/>
c. Lower GI X-ray series	<input type="radio"/> *	<input type="radio"/>
d. Nuclear medicine scan	<input type="radio"/> *	<input type="radio"/>
e. Other tests using contrast ('dye') or radioactive materials	<input type="radio"/> *	<input type="radio"/>

***Examiner Note: If 'Yes' to any responses above, reschedule bone density measurement so that at least 10 days will have passed since the tests were performed.**

4 Was a bone density measurement obtained for . . .

a. Whole body? Reason:

Yes No →

↓

Last 2 characters of scan ID #:

Date of scan: / /

b. Hip? Reason:

Yes No →

↓

Last 2 characters of scan ID #:

Date of scan: / /

Which hip was scanned? Right Left

OrthOne 1.0 T Knee MRI



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

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 Does participant weigh > 350 lbs (>159.1 kg)?
 (Examiner Note: Do not re-weigh participant. Check weight measurement on page 3 in the Clinic Visit Workbook.)

Yes No

Not eligible. Go to Question #17.

③ Have you had any surgery in the past two months?

Yes No Don't know/Refused

When was the surgery?

/ /
 Month Day Year

STOP. Schedule MRI scan 2 months after surgery date.

Not eligible. Go to Question #17.

④ Do you have a heart pacemaker?

Yes No Don't know/Refused

Not eligible. Go to Question #17.

Not eligible. Go to Question #17.

⑤ Have you ever had any surgery to insert a valve into your heart?

Yes No Don't know/Refused

Not eligible. Go to Question #17.

Not eligible. Go to Question #17.

⑥ Do you have a surgically implanted heart defibrillator?

(Examiner Note: a defibrillator is a device that 'jump starts' your heart if it starts to beat abnormally.)

Yes No Don't know/Refused

Not eligible. Go to Question #17.

Not eligible. Go to Question #17.

⑦ Do you have a surgically implanted stent (a tube that keeps your arteries open)?

Yes No Don't know/Refused

Not eligible. Go to Question #17.

Not eligible. Go to Question #17.

OrthOne 1.0 T Knee MRI (cont.)



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

8 Have you had a hearing device surgically implanted in your ear (not a regular hearing aid)?

Yes No Don't know/Refused

Not eligible.
Go to Question #17.

Not eligible.
Go to Question #17.

9 Do you have a surgically implanted insulin or drug pump?

Yes No Don't know/Refused

Not eligible.
Go to Question #17.

Not eligible.
Go to Question #17.

10 Have you ever had surgery to repair a brain aneurysm?

Yes No Don't know/Refused

Not eligible.
Go to Question #17.

Not eligible.
Go to Question #17.

11 Do you have metal fragments in your body from shrapnel, bullet fragments, etc.?

Yes No Don't know/Refused

Not eligible.
Go to Question #17.

Not eligible.
Go to Question #17.

12 Have you ever had an injury in which metal or metal fragments may have entered your eye?

Yes No Don't know/Refused

Not eligible.
Go to Question #17.

Not eligible.
Go to Question #17.

13 Do you have a bone growth stimulator implanted in either of your legs?

Yes No Don't know/Refused

Yes
↓
 (This path is crossed out)

Go to Question #15.

Not eligible.
Go to Question #17.

14 Which leg has the bone growth stimulator?

Right Left Don't Know/Refused

Do not scan right knee.

Do not scan left knee.

Not eligible.
Go to Question #17.

OrthOne 1.0 T Knee MRI (cont.)



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

15 Have you had a total knee replacement in either knee?

Yes

No

Don't know/Refused

Which knee was replaced?

Right

Left

Do not scan right knee.

Do not scan left knee.

Not eligible.
Go to Question #17.

16 Have you ever had an MRI scan?

Yes

No

Don't know/Refused

a. Were you able to complete the MRI scan?

Yes

No

Don't know

b. Why were you unable to complete the MRI scan?

(Please specify: _____)

Examiner Note: Determine if the reason makes the participant eligible or ineligible for the MRI scan.

Is participant eligible for the MRI scan?

Yes

No

Not eligible.
Go to Question #17.

c. Would you be willing to have another MRI scan?

Yes

No

Don't know

Not eligible.
Go to Question #17.

OrthOne 1.0 T Knee MRI (cont.)



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

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

VONI Yes No

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

VONIR **1** Yes **0** No →

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

1 Participant not eligible

2 Participant had right total knee replacement

3 Participant's leg did not fit in MRI scanner

4 Participant refused

5 Participant scheduled for a later date

6 Other (**Please specify:** _____)

VONOR

b. Was an MRI obtained of the left knee?

VONIL **1** Yes **0** No →

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

1 Participant not eligible

2 Participant had left total knee replacement

3 Participant's leg did not fit in MRI scanner

4 Participant refused

5 Participant scheduled for a later date

6 Other (**Please specify:** _____)

VONOL

OrthOne 1.0 T Knee MRI (cont.)



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

19 Was an OrthOne 1.0 T knee MRI obtained for each of the following sequences?

Right knee scan

- a. Axial
 Yes No → Reason: _____
- b. Sagittal
 Yes No → Reason: _____
- c. Coronal
 Yes No → Reason: _____
- d. STIR
 Yes No → Reason: _____
- e. 3 Point Dixon
 Yes No → Reason: _____
- f. Other
 Yes No → Reason: _____

Left knee scan

- a. Axial
 Yes No → Reason: _____
- b. Sagittal
 Yes No → Reason: _____
- c. Coronal
 Yes No → Reason: _____
- d. STIR
 Yes No → Reason: _____
- e. 3 Point Dixon
(Examiner Note: Only perform this sequence if right knee is not scanned.)
 Yes No → Reason: _____
- f. Other
 Yes No → Reason: _____

1.5 T Knee MRI



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

1 Was participant selected for a 1.5 T knee MRI study?

Yes

No

Which study?

- Ancillary Study
- Reliability Study

STOP. Do not complete this form.

2 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.

3 Was the participant determined eligible for the OrthOne knee MRI scan in Question #17 on the OrthOne Knee MRI form?
(Refer to Question #17 on page 32 of the Clinic Visit Workbook.)

Yes

No

Not eligible. Go to Question #6.

4 Does participant weigh > 330 lbs (>149.7 kg)?
(Examiner Note: Do not re-weigh participant. Check weight measurement on page 3 in the Clinic Visit Workbook.)

Yes

No

Not eligible. Go to Question #6.

5 Do you have claustrophobia?
(Examiner Note: Only definite claustrophobia is a firm contraindication. True claustrophobia is relatively uncommon [2-3%]. Participants with claustrophobia will know who they are. Some may say they are uncomfortable in small spaces, but may tolerate MRI without difficulty. It is useful to make an attempt in persons who seem uncertain or who have mild concern.)

Yes

No

Don't know/Refused

Are you willing to have an MRI scan?

Yes

No

Not eligible. Go to Question #6.

6 Is the participant eligible for a 1.5 T knee MRI?

Yes

No

Schedule 1.5 T knee MRI scan

Not eligible. Go to Question #8.

Physician Confirmatory Examinations



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"/>
Office Use Only		Month	Day	Year	

VO_DATEDIFF2

Study Coordinator Note:

Complete this page before physician performs the Physician Confirmatory Examinations.

BOX 1. SELF-REPORT KNEE and HIP PAIN (Examiner Note: Refer to Clinic Interview Workbook. Please mark <u>ALL</u> that apply.)			
A. Clinic Interview Question # 13. Right knee pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
B. Clinic Interview Question # 15. Left knee pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
C. Clinic Interview Question # 36. Right hip pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
D. Clinic Interview Question # 37. Left hip pain	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
E. Clinic Interview Question # 39. Right hip replaced	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Mark "Yes" to Questions # 1, 8, & 17 regarding hip replacement. </div>			
F. Clinic Interview Question # 40. Left hip replaced	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't know/Refused
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Mark "Yes" to Questions # 14, 15, & 18 regarding hip replacement. </div>			

EXAM ELIGIBILITY	
I. Is either item A or B (knee pain) marked "Yes"?	
<input type="radio"/> Yes	<input type="radio"/> No
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Perform hip and knee exams. </div>	Is either item C or D (hip pain) marked "Yes"? <input type="radio"/> Yes <input type="radio"/> No → <div style="border: 1px solid black; padding: 2px 5px;">STOP.</div>
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Perform ONLY hip exams (asterisked[*]). (Exams# *1, *8, *14, *15, *17, *18) </div>	

EXAMS TO BE COMPLETED BY PHYSICIAN	
MDEXAM	<input type="radio"/> <u>All</u> examinations (1 through 19) <input type="radio"/> Hip examinations <u>only</u> *1, *8, *14, *15, *17, and *18

Physician Confirmatory Examinations

(cont.)



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

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

Exam	Exam done? "Is this tender or painful?"
<p>*1 Trochanteric bursitis</p> <p>Has the participant had a <u>right</u> hip replacement? (Box 1, letter E on page 1.)</p> <p> <input type="radio"/> No → <input type="radio"/> Yes </p> <div style="border: 1px solid black; padding: 5px; margin-left: 100px; width: fit-content;"> Do NOT perform <u>right</u> trochanteric bursitis exam. </div>	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN1R</p> <p>7 <input type="radio"/> Refused 8 <input type="radio"/> Not done</p>
<p>2 Iliotibial band</p>	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN2R</p> <p>7 <input type="radio"/> Refused 8 <input type="radio"/> Not done</p>

Physician Confirmatory Examinations

(cont.)



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

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

Exam	Exam done? "Is this tender or painful?"
3 Anserine bursa	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN3R 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
4 Medial tibio-femoral joint line	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN4R 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
5 Lateral tibio-femoral joint line	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN5R 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
6 Patellar tenderness	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN6R 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
7 Medial knee fat pad tenderness	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN7R 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
*8 Hip internal rotation <u>pain</u> <input type="radio"/> No Has the participant had a <u>right</u> hip replacement? <input type="radio"/> Yes (Box 1, letter E on page 1.)	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN8R 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> Do NOT perform <u>right</u> hip pain exam. </div>	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> Where does it hurt? (Show card # 2. Mark <u>all</u> that apply.) </div>
MDIRP1R MDIRP2R MDIRP3R MDIRP4R MDIRP5R MDIRP6R	<input type="radio"/> 1 Groin/inside leg near hip <input type="radio"/> 2 Outside of leg near hip <input type="radio"/> 3 Front of leg near hip <input type="radio"/> 4 Buttocks <input type="radio"/> 5 Lower back 1 = YES <input type="radio"/> Don't know

Physician Confirmatory Examinations

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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"/>
<i>Office Use Only</i>		Month	Day	Year	

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

Exam	Exam done? "Is this tender or painful?"
9 Anserine bursa	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN9L 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
10 Medial tibio-femoral joint line	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN10L 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
11 Lateral tibio-femoral joint line	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN11L 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
12 Patellar tenderness	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN12L 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
13 Medial knee fat pad tenderness	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN13L 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
*14 Hip internal rotation <u>pain</u> <input type="radio"/> No <input type="radio"/> Yes Has the participant had a <u>left</u> hip replacement? (Box 1, letter F on page 1.)	MDPN14L 1 <input type="radio"/> Yes 0 <input type="radio"/> No 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> Do NOT perform <u>left</u> hip pain exam. </div>	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> Where does it hurt? (Show card # 2, Mark <u>all</u> that apply.) </div>
MDIRP1L MDIRP2L MDIRP3L MDIRP4L MDIRP5L MDIRP6L	<input type="radio"/> 1 Groin/inside leg near hip <input type="radio"/> 2 Outside of leg near hip <input type="radio"/> 3 Front of leg near hip <input type="radio"/> 4 Buttocks <input type="radio"/> 5 Lower back 1 = YES <input type="radio"/> Don't know

Physician Confirmatory Examinations

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

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

Exam	Exam done? "Is this tender or painful?"
<p>*15 Trochanteric bursitis</p> <p>Has the participant had a <u>left</u> hip replacement? (Box 1, letter F on page 1.)</p> <p><input type="radio"/> No <input type="radio"/> Yes</p> <p>Do NOT perform <u>left</u> trochanteric bursitis exam.</p>	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN15L</p> <p>7 <input type="radio"/> Refused 8 <input type="radio"/> Not done</p>
<p>*16 Iliotibial band</p>	<p>1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN16L</p> <p>7 <input type="radio"/> Refused 8 <input type="radio"/> Not done</p>

Hip internal rotation exams: *Participant is sitting.*

Exam	Exam done?	How many degrees was the limit of motion?
<p>*17 Right hip internal rotation</p> <p>Has the participant had a <u>right</u> hip replacement? (Box 1, letter E on page 1.)</p> <p><input type="radio"/> No <input type="radio"/> Yes</p> <p>Do NOT perform <u>right</u> hip exam.</p>		<p><input type="text"/> <input type="text"/> <input type="text"/> degrees</p> <p>MDLOMR</p>
<p>*18 Left hip internal rotation</p> <p>Has the participant had a <u>left</u> hip replacement? (Box 1, letter F on page 1.)</p> <p><input type="radio"/> No <input type="radio"/> Yes</p> <p>Do NOT perform <u>left</u> hip exam.</p>		<p><input type="text"/> <input type="text"/> <input type="text"/> degrees</p> <p>MDLOML</p>

Physician Confirmatory Examinations

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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"/>
<i>Office Use Only</i>		Month		Day		Year		



Tenderpoint exams: *Participant is sitting.*

19 Was pain present during either the right or left medial knee fat pad exams # 7 and/or # 13?

1 Yes 0 No **MDEX19**



Exam	Exam done? "Is this tender or painful?"
a. Right elbow tenderpoint	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN19A 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
b. Left elbow tenderpoint	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN19B 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
c. Right trapezius tenderpoint	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN19C 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done
d. Left trapezius tenderpoint	1 <input type="radio"/> Yes 0 <input type="radio"/> No MDPN19D 7 <input type="radio"/> Refused 8 <input type="radio"/> Not done