This document displays the MOST data collection forms annotated with the variable names and data values that are used for the instruments and measurements conducted at the 60-month time point.

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**ANALYST NOTES**

**Released Variables**

Released variables are displayed in bold blue font.

Example: MOSTID

**Variables Not Released**

Variables not released are displayed in gray font and lined out.

Example: V3SDAT2

*Note: Where all the variables on a page are not released, the page is crossed out with an “X”.

**Calculated Variables**

Calculated variables are displayed in bold blue font within a text box.

Example: V3MCOMOR
Knee Symptoms

First, I am going to ask you some questions about pain, aching, or stiffness in or around your knees. The first set of questions are about your right knee. Then I will ask you the same questions about your left knee.

Right Knee

The first questions will be specifically about your right knee.

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

   1a. During the past 12 months, have you had pain, aching, or stiffness in your right knee on most days for at least one month?
   - Yes
   - No
   - Don't know

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

   2a. During the past 30 days, have you had pain, aching, or stiffness in your right knee on most days?
   - Yes
   - No
   - Don't know
Knee Symptoms

Left Knee

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

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

   - Yes
   - No
   - Don't know/Refused

   V312ML 1 0 8

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

   - Yes
   - No
   - Don't know

   V312MSL 1 0 8

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

   - Yes
   - No
   - Don't know/Refused

   V330DL 1 0 8

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

   - Yes
   - No
   - Don't know

   V330MSL 1 0 8

Both Knees

Now I'll ask you about both knees.

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

   - Yes
   - No
   - Don't know/Refused

   V3LA 1 0 8

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

   - Days

   V3LADAY

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

   - Yes
   - No
   - Don't know

   V3AVOIDT
The next few questions are about MRI eligibility.

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

6b. What type of surgery or implant was it?

When was the surgery?

- [ ] Month  /  [ ] Day  /  [ ] Year

6c. The next few questions will be about specific implants. Please tell me whether any of the following was implanted in your body during surgery:

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

6d. Interviewer Note:

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

- [ ] Yes Not eligible for MRI. Go to Page 5, Question #11 and mark "No."
- [ ] No

Go to Question #7.
6e. Please tell me whether any of the following was implanted in your body:

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

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

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

9. **Interviewer Note:**

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

   ○ Yes ○ No

9a. Do you have or would you be willing to ask your doctor for your medical records so that we could determine whether it would be safe for you to have an MRI scan?

   ○ Yes ○ No

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

   **Not eligible for MRI. Go to Page 5, Question #11 and mark "No."**
10. **Interviewer Note:** Is there any other reason why this participant would not be eligible for an MRI? (e.g., participant has had both knees replaced)

   - [ ] Yes
   - [ ] No

   What is the reason?

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

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

   - [ ] Yes
   - [ ] No

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

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

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

   - [ ] Yes
   - [ ] No
   - [ ] Don't know/Refused

12a. What is the date of your scheduled surgery?

   Month / Day / Year

   What type of surgery will you have?

   Interviewer Note: Refer to list of surgeries/procedures that do not require a 2-month wait. If surgery is on that list, mark "No" for this question. If a 2-month wait is required, go to page 6, Question #13. Do not scan today's Telephone Interview forms. Re-contact 2 months after surgery to reassess eligibility.

[Page 5]
Contact Information

13. We would like to update all of your contact information this year. The address that we currently have listed for you is:
(Interviewer Note: Please review the participant's contact information and confirm that the address you have for the participant is correct.)
Is the address that we currently have correct?

   ○ Yes   ○ No

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

14. The telephone number(s) that we currently have for you is (are):
(Interviewer Note: Please review the participant's contact information and confirm that the telephone number(s) you have for the participant are correct.)
Are the telephone number(s) that we currently have correct?

   ○ Yes   ○ No

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

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

   ○ Yes   ○ No   ○ Don't know/Refused

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

16. **Interviewer Note:** Has the participant identified their next of kin?
   - Yes
   - No → Go to Question #17

16a. **Interviewer Note:** Please review the participant’s next of kin contact information from baseline.
   
   You previously told us the name and address of your next of kin. Please tell me if the information that I have is still correct. Is the name and address of your next of kin correct?
   - Yes
   - No
   - Don’t know
   - Refused
   
   Go to Question #18

17. Please tell me the name, address, and telephone number of your next of kin. How is this person related to you?
   **Interviewer Note:** Please record the name, street address, city, state, zip code, telephone number, and how the person is related to the participant.

18. **Interviewer Note:** Has the participant identified their two contacts?
   - Yes
   - No → Go to Question #19

18a. **Interviewer Note:** Please review the participant’s information for their two contacts.
   
   You previously told us the names and addresses of your two contacts. Please tell me if the information that I have is still correct. Are the names and addresses of your two contacts correct?
   - Yes
   - No
   - Don’t know
   - Refused
   
   Go to next page

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

   Please tell me the name, address, and telephone number of your second contact. How is this person related to you?
   **Interviewer Note:** For both contacts, please record the name, street address, city, state, zip code, telephone number, and how the person is related to the participant.

---

[Table]

<table>
<thead>
<tr>
<th>Visit</th>
<th>MOST ID #</th>
<th>Acrostic</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>72-month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>84-month</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Clinic Visit Eligibility

BOX A

○ CLINIC VISIT - WITH MRI

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

○ Appointment scheduled Date:_______ Time:_______
○ Call back for appointment Date:_______ Time:_______

○ CLINIC VISIT - NO MRI

"Thank you for your time and for answering our questions. We’d like to schedule you for a clinic visit. Before I schedule your appointment, do you have any questions?" (1. Read script from operations manual for scheduling a clinic visit with no MRI. 2. Determine if participant has had bilateral knee replacements. If so, read script from operations manual for scheduling clinic visit with no specimen collection.)

○ Appointment scheduled Date:_______ Time:_______
○ Call back for appointment Date:_______ Time:_______

○ NOT INTERESTED

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

Thank you for your time and for answering our questions. Do you have any questions?"

(Follow protocol for participants who are not interested in coming in for clinic visit. Ask participant if they want to think about possibly coming in to clinic at a later date. If they say "No," ask if they would mind staying on the phone for about 10 more minutes so you can ask them a few more questions. Administer Missed Clinic Visit Telephone Interview.)
Arthritis Diagnosis

1. Since we last contacted you, about 2 years ago, has your doctor told you that you have arthritis?

   V3ARTH  □ Yes  □ No

   (Please specify: ____________________________ )

Go to Page 2, Question #2.

What kind of arthritis did your doctor say it was? Did your doctor say you had...

(Please answer "Yes," "No," or "Don't know" for all questions below.)

<table>
<thead>
<tr>
<th>Question</th>
<th>V3RADXRX</th>
<th>V3RAMED</th>
<th>V3RA</th>
<th>V3KNOA</th>
<th>V3HPOA</th>
<th>V3HFOA</th>
<th>V3OJOA</th>
<th>V3GOUT</th>
<th>V3OTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Rheumatoid arthritis?</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>0</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Osteoarthritis or degenerative arthritis in your knee?</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>0</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Osteoarthritis or degenerative arthritis in your hip?</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>0</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Osteoarthritis or degenerative arthritis in your hand or fingers?</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>0</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Osteoarthritis or degenerative arthritis in some other joint?</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>0</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Gout?</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>0</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Some other type of arthritis?</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>0</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(NOT COLLECTED)
Health History and Medical Conditions

2. Since we last contacted you, about 2 years ago, have you had a heart attack?
   
   V3HRTAT  1  Yes  0  No  8  Don't know

3. Since we last contacted you, about 2 years ago, have you had an operation to unclog or bypass the arteries in your heart?
   
   V3UNCLOG  1  Yes  0  No  8  Don't know

4. Since we last contacted you, about 2 years ago, have you 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.)
   
   V3HRTFA  1  Yes  0  No  8  Don't know

5. Since we last contacted you, about 2 years ago, have you had an operation to unclog or bypass the arteries in your legs?
   
   V3BYPASS  1  Yes  0  No  8  Don't know

6. Since we last contacted you, about 2 years ago, have you had a stroke, cerebrovascular accident, blood clot or bleeding in the brain, or transient ischemic attack (TIA)?
   
   V3STROKE  1  Yes  0  No  8  Don't know
   
   a. Do you have difficulty moving an arm or leg as a result of the stroke or cerebrovascular accident?
      
      V3MOVE  1  Yes  0  No  8  Don't know
      
      Go to Question #7.

7. Do you have asthma?
   
   V3ASThma  1  Yes  0  No  8  Don't know
   
   a. Do you take medicines for your asthma?
      
      V3ASTRX  1  Yes  0  No  8  Don't know
      
      Go to Page 3, Question #8.

   b. When do you usually take the medicine? (Please mark one.)
      
      V3AWHEN  1  Only with flare-ups of my asthma  0  Regularly, even when I'm not having a flare-up
      
      Go to Page 3, Question #8.
Health History and Medical Conditions

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

- **V3COPD**
  - 1  Yes
  - 0  No
  - 8  Don’t know

  a. Do you take medicines for your lung disease?

  - **V3LUNRX**
    - 1  Yes
    - 0  No
    - 8  Don’t know

    b. When do you usually take the medicine? *(Please mark one.)*
    - **V3LWHEN**
      - 1  Only with flare-ups of my emphysema, bronchitis or COPD
      - 2  Regularly, even when I'm not having a flare-up

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

- **V3ULCER**
  - 1  Yes
  - 0  No
  - 8  Don’t know

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

- **V3ULCDX**
  - 1  Yes
  - 0  No
  - 8  Don’t know

10. Do you have diabetes *(high blood sugar)*?

- **V3DIABT**
  - 1  Yes
  - 0  No
  - 8  Don’t know

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

  - **V3DIET**
    - 1  modifying my diet
  - **V3DRX**
    - 1  medications taken by mouth
  - **V3INJ**
    - 1  insulin injections
  - **V3NONE**
    - 1  not treated

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

  - **V3KID**
    - 1  Problems with your kidneys
  - **V3DEYE**
    - 1  Problems with your eyes, treated by an ophthalmologist
  - **V3DDK**
    - 1  Has not caused problems
11. Since we last contacted you, about 2 years ago, have you had serious problems with your kidneys?

Yes ☐ No ☐ Don’t know ☐

Go to Question #12.

12. Do you have any of the following conditions?

a. Alzheimer’s Disease, or another form of dementia?

Yes ☐ No ☐ Don’t know ☐

b. Cirrhosis, or serious liver damage?

Yes ☐ No ☐ Don’t know ☐

c. Leukemia or polycythemia vera?

Yes ☐ No ☐ Don’t know ☐

d. Lymphoma?

Yes ☐ No ☐ Don’t know ☐

e. Cancer, other than skin cancer, leukemia or lymphoma?

Yes ☐ No ☐ Don’t know ☐

ei. Has the cancer spread, or metastasized to other parts of your body?

Yes ☐ No ☐ Don’t know ☐

f. AIDS?

Yes ☐ No ☐ Don’t know ☐
Injuries, Fractures, Falls

13. Since we last contacted you, about 2 years ago, did a doctor tell you that you broke or fractured a bone?

V3BONE 1 o Yes 0 o No

Go to Question #14.

a. Which bones did a doctor say you had broken? (Mark all that apply.)

V3FXHIP 1 o Hip
V3FXPLV o Pelvis
V3FXTHF o Thigh (femur--not hip)
V3FKNE o Knee (patella/tibial plateau)
V3FXLWL o Lower leg (tibia/fibula)
V3FXANK o Ankle
V3FXTT o Foot/toe
V3FXTLB o Tailbone (coccyx/sacrum)
V3FXWRT o Wrist/forearm (radius/ulna)
V3FOTH o Other (Please specify: ____________________________ )

14. Are you afraid of falling?

V3FALLF 1 o Yes 0 o No

Go to Page 6, Question #15.

a. Would you say that you are afraid of falling . . . ?

V3FALLFF o Very often
V3FALLFF o Often
V3FALLFF o Occasionally
V3FALLFF o Rarely
**Balance Confidence**

For each activity, please indicate how much confidence you have that you will NOT lose your balance or become unsteady when performing the activity. Use the scale below, where 0% indicates you have no confidence that you can perform the activity without losing your balance or becoming unsteady, and 100% indicates that you have complete confidence that you can perform the activity without losing your balance or becoming unsteady.

*Please fill in a bubble below for each of the activities. Mark only one bubble along the scale from 0 to 100%.*

<table>
<thead>
<tr>
<th>No confidence</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
</tr>
</thead>
</table>

| Complete confidence |  |

16. How confident are you that you will NOT lose your balance or become unsteady when you are . . .

<table>
<thead>
<tr>
<th>Activity</th>
<th>No confidence</th>
<th>Complete confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Walking in the house?</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>b. Going up and down stairs?</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>c. Bending down to pick up a slipper off the closet floor?</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>d. Stretching to take a small can off a shelf at eye level?</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>e. Getting up on your toes to reach an object above your head?</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>f. Getting up on a chair (or a stepladder) to get an object?</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>g. Sweeping the floor?</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>h. Going out of the house to get to a car parked in the driveway?</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>
### Activities-specific Balance Confidence (ABC) Scale

**Please fill in a bubble below for each of the activities. Mark only one bubble along the scale from 0 to 100%.**

<table>
<thead>
<tr>
<th>No confidence</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
<th>Complete confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Getting in and out of the car (regular car)?</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>No confidence</td>
</tr>
<tr>
<td>j. Crossing a parking lot to get to the shopping center?</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>No confidence</td>
</tr>
<tr>
<td>k. Going up or down a slope (access ramp)?</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>No confidence</td>
</tr>
<tr>
<td>l. Walking through a shopping center crowded with people who are in a rush?</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>No confidence</td>
</tr>
<tr>
<td>m. Getting jostled by people as you are walking through a shopping center?</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>No confidence</td>
</tr>
<tr>
<td>n. Using an escalator while holding the railing?</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>No confidence</td>
</tr>
<tr>
<td>o. Using an escalator without being able to hold the railing because your arms are full?</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>No confidence</td>
</tr>
<tr>
<td>p. Walking on icy sidewalks?</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>No confidence</td>
</tr>
</tbody>
</table>

**How confident are you that you will NOT lose your balance or become unsteady when you are . . .**

- i. Getting in and out of the car (regular car)?
- j. Crossing a parking lot to get to the shopping center?
- k. Going up or down a slope (access ramp)?
- l. Walking through a shopping center crowded with people who are in a rush?
- m. Getting jostled by people as you are walking through a shopping center?
- n. Using an escalator while holding the railing?
- o. Using an escalator without being able to hold the railing because your arms are full?
- p. Walking on icy sidewalks?
Dealing with Pain

Individuals who experience pain have developed a number of ways to cope or deal with their pain. Below are several things that people have reported saying to themselves or doing when they feel pain. For each, please indicate, using the scale below, how much you do that when you feel pain, ... where 0 indicates you never do that when you are feeling pain, ... a 3 indicates you sometimes do that when you are feeling pain, ... and a 6 indicates you always do that when you are feeling pain.

For each activity, please mark one of the six bubbles along the scale from 0 to 6.

When I feel pain ...

17. I think of things I enjoy doing.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never do that</td>
<td>Sometimes do that</td>
<td>Always do that</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. I pray for the pain to stop.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never do that</td>
<td>Sometimes do that</td>
<td>Always do that</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. I don’t pay any attention to it.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never do that</td>
<td>Sometimes do that</td>
<td>Always do that</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. I feel it’s terrible and that it’s never going to get any better.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never do that</td>
<td>Sometimes do that</td>
<td>Always do that</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Joint Pain, Aching, and Stiffness

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

V3JPAIN  

Yes 0 No

Go to Page #12, Question #22.

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.)

Foot joints are on next page (Page 11.)
Joint Pain, Aching, and Stiffness

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 Foot**
- V3FF1L
- V3FF2L
- V3FF3L
- V3FF4L
- V3FF5L
- V3FF6L
- V3FF7L
- V3FF8L
- V3FF9L
- V3L_FFOOT

**Right Foot**
- V3FF1R
- V3FF2R
- V3FF3R
- V3FF4R
- V3FF5R
- V3FF6R
- V3FF7R
- V3FF8R
- V3FF9R
- V3R_FFOOT

**Left Hand**
- V3BF1L
- V3BF2L
- V3BF3L
- V3BF4L
- V3BF5L
- V3BF6L
- V3BF7L
- V3BF8L
- V3BF9L
- V3L_BFOOT

**Right Hand**
- V3BF1R
- V3BF2R
- V3BF3R
- V3BF4R
- V3BF5R
- V3BF6R
- V3BF7R
- V3BF8R
- V3BF9R
- V3R_BFOOT

Any marked "Yes"?

**Left Foot**

Any marked "Yes"?

**Right Foot**

Any marked "Yes"?

**Left Hand**

Any marked "Yes"?

**Right Hand**

Any marked "Yes"?

**YES = 1**

***Page 11***

MOST Follow-up
Self-Administered Questionnaire - Home
BZ
Back Pain and Function

22. During the past 30 days, have you had any back pain?

V3PAIN 1○ Yes 0○ No

Go to Page 13, Question #23.

a. How often were you bothered by back pain in the past 30 days? (Mark only one response.)

V3FREQ 1○ All of the time 2○ Most of the time 3○ Some of the time 4○ Rarely 5○ Never

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

V3SERV 1○ Mild 2○ Moderate 3○ Severe

c. In what part or parts of your back is the pain usually located? (Mark all areas on the back that apply with an X)

CLINIC USE ONLY

1 ○ NK V3NK
1 ○ UB V3UB
1 ○ MB V3MB
1 ○ LB V3LB V3_LBP
1 ○ BK V3BK

LOWER BACK

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

V3BPLA 1○ Yes 0○ No

Go to Page 13, Question #23.

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

V3BDDAY ___ days

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

V3BPLAD ___ days
23. During the past 30 days, have you taken any of the following medications for joint pain or arthritis?

- Aspirin
- Advil, Motrin, Nuprin (Ibuprofen)
- Aleve or Naprosyn (Naproxen)
- Anaprox or Anaprox DS (Naproxen)
- Celebrex (Celecoxib)
- Tylenol (Acetaminophen)
- Ansaid (Flurbiprofen)
- Arthrotec (Diclofenac/Misoprostol)
- Cataflam (Diclofenac)
- Clinoril (Sulindac)
- Daypro (Oxaprozin)
- Dolobid (Diflunisal)
- Feldene (Piroxicam)
- Indocin (Indomethacin)
- Indocin SR (Indomethacin)
- Lodine (Etodolac)
- Lodine XL (Etodolac)
- Meclofenamate (Meclofenamate)
- Mobic (Meloxicam)
- Nalfon (Fenoprofen)
- Naprelan (Naproxen)
- Orudis (Ketoprofen)
- Oruvail (Ketoprofen)
- Ponstel (Mefenamic acid)
- Relafen (Nabumetone)
- Tolectin (Tolmetin)
- Tolectin DS (Tolmetin)
- Toradol (Ketorolac)
- Voltaren (Diclofenac)
- Voltaren-XR (Diclofenac)

V3ARTHRX 1 Yes

Go to Page 14, Question #24.

V3MOFT

a. How often do you take any of these medications for joint pain or arthritis?

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

-Page 13-
24. During the past 30 days, have you taken any of the following stronger medications for joint pain or arthritis?

- Actiq (fentanyloral)
- Avinza (morphine)
- Buprenex (buprenorphine)
- Codeine
- Darvon (propoxyphene)
- Demerol (meperidine)
- Dilaudid (hydromorphone)
- Dolophine (methadone)
- Duragesic patch (fentanyl)
- Kadian (morphine)
- Levo-Dromoran (levorphanol)
- Lortab (hydrocodone + APAP)
- Medhadose (methadone)
- Meperidine (nalbuphine)
- MS Contin (morphine sulphate)
- MSIR (morphine)
- Nubain (nalbuphine)
- Numorphan (oxymorphone)
- Oramorph SR (morphine)
- OxyContin (oxycodone)
- Oxydose (oxycodone)
- Oxyfast (oxycodone)
- OxyIR (oxycodone)
- Percocet (oxycodone + APAP)
- Percodan (oxycodone+terephthalate)
- Roxanol (morphine)
- Roxicodone (oxycodone)
- Stadol (butorphanol)
- Stadol NS (butorphanol nasal)
- Sufenta (sufentanil)
- Synalgos-DC
- Talacen (pentazocine + APAP)
- Talwin (pentazocine)
- Talwin-NX (pentazocine + APAP)
- Tylenol w/codeine
- Tylox (oxycodone + APAP)
- Ultiva (remifentanil)
- Ultram (tramadol hydrochloride)
- Vicodin (hydrocodone + APAP)

V3SMED

1. Yes
0. No

Go to Page 15, Question #25.

a. How often do you take any of these medications for joint pain or arthritis?

5. More than once a day
4. Once a day
3. Three to five times a week
2. Once or twice a week
1. Less than once a week
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.

25. In general, would you say your health is:
   1. Excellent
   2. Very good
   3. Good
   4. Fair
   5. Poor

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?

26. Accomplished less than you would like
    1. Yes
    0. No
    V3SF4

27. Were limited in the kind of work or other activities
    1. Yes
    0. No
    V3SF5

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)?

28. Accomplished less than you would like
    1. Yes
    0. No
    V3SF6

29. Didn't do work or other activities as carefully as usual
    1. Yes
    0. No
    V3SF7
Health Survey

30. 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.)*

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>A good bit of the time</th>
<th>Some of the time</th>
<th>A little bit of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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

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

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

31. Have you felt calm and peaceful?

32. Did you have a lot of energy?

33. Have you felt downhearted and blue?

34. 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.)*
35. 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? *(Fill in the circle on each line.)*

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Yes, limited a lot</th>
<th>Yes, limited a little</th>
<th>No, not limited at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>c. Lifting or carrying groceries?</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>d. Climbing <strong>several</strong> flights of stairs?</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>e. Climbing <strong>one</strong> flight of stairs?</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>f. Bending, kneeling, or stooping?</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>g. Walking more than a mile?</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>h. Walking <strong>several</strong> hundred yards?</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>i. Walking <strong>one</strong> hundred yards?</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>j. Bathing or dressing yourself?</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>
36. 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.

<table>
<thead>
<tr>
<th>V3CESDA</th>
<th>Rarely or None of the time (&lt;1 day)</th>
<th>Some of the time (1-2 days)</th>
<th>Much of the time (3-4 days)</th>
<th>Most or All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I was bothered by things that usually don't bother me.</td>
<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>V3CESDB</td>
<td>b. I did not feel like eating: my appetite was poor.</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>V3CESDC</td>
<td>c. I felt that I could not shake off the blues even with help from my family and friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>V3CESDD</td>
<td>d. I felt that I was just as good as other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>V3CESDE</td>
<td>e. I had trouble keeping my mind on what I was doing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>V3CESDF</td>
<td>f. I was depressed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>V3CESDG</td>
<td>g. I felt that everything I did was an effort.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>V3CESDH</td>
<td>h. I felt hopeful about the future.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>V3CESDI</td>
<td>i. I thought my life had been a failure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>V3CESDJ</td>
<td>j. I felt fearful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>k. My sleep was restless</th>
<th>Rarely or None of the time (&lt;1 day)</th>
<th>Some of the time (1-2 days)</th>
<th>Much of the time (3-4 days)</th>
<th>Most or All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>l. I was happy</td>
<td>v3CESDL</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>m. It seemed that I talked less than usual</td>
<td>v3CESDM</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>n. I felt lonely</td>
<td>v3CESDN</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>o. People were unfriendly</td>
<td>v3CESDO</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>p. I enjoyed life</td>
<td>v3CESDP</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>q. I had crying spells</td>
<td>v3CESDQ</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>r. I felt sad</td>
<td>v3CESDR</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>s. I felt that people disliked me</td>
<td>v3CESDS</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>t. I could not get going</td>
<td>v3CESDT</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Sleep and Fatigue

37. During the past 7 days, how would you rate your sleep quality overall?
   - Very good
   - Fairly good
   - Fairly bad
   - Very bad

38. Fatigue is a feeling of being worn out, pooped, sluggish, run down, tired, or lacking energy. During the past 7 days, what number between 0 and 10 best describes your usual level of fatigue?
   A zero (0) would mean ‘no fatigue’ and ten (10) would mean ‘fatigue as bad as it can be.’

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

   No fatigue

   Fatigue as bad as it can be
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.

<table>
<thead>
<tr>
<th>To what extent do you feel limited in...?</th>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat</th>
<th>A lot</th>
<th>Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>39. Visiting friends and family in their homes.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>40. Providing care or assistance to others. This may include providing personal care, transportation, and running errands for family members or friends.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>41. Taking care of the inside of your home. This includes managing and taking responsibility for homemaking, laundry, housecleaning and minor household repairs.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>42. Working at a volunteer job outside your home.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>43. Taking part in active recreation. This may include bowling, golf, tennis, hiking, jogging, or swimming.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>44. Traveling out of town for at least an overnight stay.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>45. Taking part in a regular fitness program. This may include walking for exercise, stationary biking, weight lifting, or exercise classes.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>46. Going out with others to public places such as restaurants or movies.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>To what extent do you feel limited in…?</td>
<td>Not at all</td>
<td>A little</td>
<td>Somewhat</td>
<td>A lot</td>
<td>Completely</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------</td>
<td>---------</td>
<td>----------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>47. Taking care of your own personal care needs. This includes bathing, dressing, and toileting.</td>
<td>5 V3FDI9</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>48. Taking part in organized social activities. This may include clubs, card playing, senior center events, community or religious groups.</td>
<td>5 V3FDI10</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>49. 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.</td>
<td>5 V3FDI11</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>50. Preparing meals for yourself. This includes planning, cooking, serving, and cleaning up.</td>
<td>5 V3FDI12</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Helpful Aids and Devices

51. Do you usually use any of the following AIDS OR DEVICES for walking indoors around your home?  
(Please mark all that apply.)

V3AICANE ○ Cane
V3AICRUT ○ Crutches
V3AIWLK ○ Walker
V3AIWHL ○ Wheelchair
V3AIOTH ○ Other  (Please specify: __________________________)  

52. Do you usually use any of the following AIDS OR DEVICES for walking outdoors or when you go out shopping?  
(Please mark all that apply.)

V3AOCANE ○ Cane
V3AOCRUT ○ Crutches
V3AOWLK ○ Walker
V3AOWHL ○ Wheelchair
V3AOOTH ○ Other  (Please specify: __________________________)  

53. Do you usually use any of the following AIDS OR DEVICES for going up or down stairs?  
(Please mark all that apply.)

V3ASCANE ○ Cane
V3ASLIFT ○ Stair lift
V3ASELEV ○ Elevator
V3ASOTH ○ Other  (Please specify: __________________________)  

54. Do you usually use any of the following AIDS OR DEVICES for getting up from a chair or bed, or using the toilet?  
(Please mark all that apply.)

V3AUNCHR ○ Special built-up or lift chair
V3AUCANE ○ Cane
V3AUWLK ○ Walker
V3AUCRUT ○ Crutches  ○ I do not use any of these devices

YES = 1

V3AUTLT ○ Built up or raised toilet seat
V3AUGRAB ○ Grab bars
V3AUOTH ○ Other  (Please specify: __________________________)
Current Employment

55. 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.)*

- V3PAY
  - 1 ○ Yes
  - 0 ○ No
  - Go to Question #56.

  a. Do you do at least 15 hours of unpaid work per week for a business or farm owned by a member of your family? *(Work that you do to care for family members or as a volunteer does not apply.)*

- V3NOPAY
  - 1 ○ Yes
  - 0 ○ No
  - Go to Question #56.

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

- V3HLTH
  - 1 ○ Yes
  - 0 ○ No
  - Go to Page 25, Question #58.

56. 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.)*

- V3HRSWK
  - Number of hours worked per week

57. 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.)*

- V3MIS
  - Number of days missed in the past 3 months
58. How difficult is it for you to meet monthly payments on your [family's] bills?
   ○ Not at all difficult
   ○ Not very difficult
   ○ Somewhat difficult
   ○ Very difficult
   ○ Unable
   V3BILL

59. Do you live by yourself or do you live with a spouse, family member(s), or roommate(s)?
   V3ALONE
   1. Live alone
   2. Live with my spouse, family member(s), or roommate(s)
   a. Not counting yourself, how many people live with you?
   V3HSHOLD Number of other people in household
   b. How many of these people are under the age of 18?
   V3LIV18 Number of people under the age of 18
Scoring for WOMAC® Likert 3.1

MOST uses a modified version of the WOMAC® Likert 3.1 instrument. WOMAC® is a registered trademark (CDN No. TMA 545,986), Copyright 1996 Nicholas Bellamy, All Rights Reserved. This copyrighted instrument may not be displayed. Therefore page 1, the bottom of page 2, the top and bottom of page 3, and all of pages 4, 5, 7, and 8 of the MOST Follow-up Self-Administered Questionnaire – Clinic are not being displayed.

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

WOMAC® subscales

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

**Knee pain**

The individual items in the pain subscale are:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Variable (right knee)</th>
<th>Variable (left knee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td>V3Q1KR</td>
<td>V3Q1KL</td>
</tr>
<tr>
<td>Up stairs</td>
<td>V3UPR</td>
<td>V3UPL</td>
</tr>
<tr>
<td>Down stairs</td>
<td>V3DOWNR</td>
<td>V3DOWNL</td>
</tr>
<tr>
<td>Stairs (calculated)</td>
<td>V3Q2KR</td>
<td>V3Q2KL</td>
</tr>
<tr>
<td>In bed</td>
<td>V3Q3KR</td>
<td>V3Q3KL</td>
</tr>
<tr>
<td>Sit or lie down</td>
<td>V3Q4KR</td>
<td>V3Q4KL</td>
</tr>
<tr>
<td>Standing</td>
<td>V3Q5KR</td>
<td>V3Q5KL</td>
</tr>
</tbody>
</table>

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: V3UPR, V3UPL, V3DOWNR, and V3DOWNL. “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.

<table>
<thead>
<tr>
<th>Score</th>
<th>Variable (right knee)</th>
<th>Variable (left knee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain subscale scores</td>
<td>V3WOPNKR</td>
<td>V3WOPNKL</td>
</tr>
</tbody>
</table>

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

The individual items in the stiffness subscale are:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Variable (right knee)</th>
<th>Variable (left knee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In morning</td>
<td>V3Q6KR</td>
<td>V3Q6KL</td>
</tr>
<tr>
<td>Later in day</td>
<td>V3Q7KR</td>
<td>V3Q7KL</td>
</tr>
</tbody>
</table>

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.

**Disability**

The individual items in the disability subscale are:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Variable (either knee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Down stairs</td>
<td>V3Q8K</td>
</tr>
<tr>
<td>Up stairs</td>
<td>V3Q9K</td>
</tr>
<tr>
<td>Stand from sitting</td>
<td>V3Q10K</td>
</tr>
<tr>
<td>Standing</td>
<td>V3Q11K</td>
</tr>
<tr>
<td>Bending</td>
<td>V3Q12K</td>
</tr>
<tr>
<td>Walking</td>
<td>V3Q13K</td>
</tr>
<tr>
<td>In car/out of car</td>
<td>V3Q14K</td>
</tr>
<tr>
<td>Shopping</td>
<td>V3Q15K</td>
</tr>
<tr>
<td>Socks on</td>
<td>V3Q16K</td>
</tr>
<tr>
<td>Get out of bed</td>
<td>V3Q17K</td>
</tr>
<tr>
<td>Socks off</td>
<td>V3Q18K</td>
</tr>
<tr>
<td>Lying down</td>
<td>V3Q19K</td>
</tr>
<tr>
<td>Bathing</td>
<td>V3Q20K</td>
</tr>
<tr>
<td>Sitting</td>
<td>V3Q21K</td>
</tr>
<tr>
<td>On/off toilet</td>
<td>V3Q22K</td>
</tr>
<tr>
<td>Heavy chores</td>
<td>V3Q23K</td>
</tr>
<tr>
<td>Light chores</td>
<td>V2Q24K</td>
</tr>
</tbody>
</table>

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: V3Q8K, V3Q9K, V3Q12K, V3Q15K, V3Q23K, and V3Q24K. “Don’t do” is set to missing.

The disability subscale possible score range is 0-68.

(Note: the top of page 2, bottom of page 4, and complete pages 3, 5, 6, 8, and 9 of the MOST Follow-up 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.

<table>
<thead>
<tr>
<th>Score</th>
<th>Variable (right knee)</th>
<th>Variable (left knee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total scores</td>
<td>V3WOTOTR</td>
<td>V3WOTOTL</td>
</tr>
</tbody>
</table>

**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 >= two pain, both stiffness, or >= four physical function items are omitted, the patient’s response is regarded as invalid and the deficient subscale(s) should not be used in analysis. Where one pain, one stiffness, or 1-3 physical function items are missing, we suggest substituting the average value for the subscale in lieu of the missing item value(s). This method is similar to that employed for other indices (e.g., SF-36).”

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

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")

0 10 20 30 40 50 60 70 80 90 100

no pain

Clinic Use Only

V3VASKR

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

0 10 20 30 40 50 60 70 80 90 100

no pain  pain as bad as it could be

V3VASKL
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)?

<table>
<thead>
<tr>
<th></th>
<th>Squatting</th>
<th>Running/jogging</th>
<th>Jumping</th>
<th>Twisting/pivoting on your knees</th>
<th>Kneeling</th>
</tr>
</thead>
<tbody>
<tr>
<td>V3SP1K</td>
<td>0 none</td>
<td>0 none</td>
<td>0 none</td>
<td>0 none</td>
<td>0 none</td>
</tr>
<tr>
<td>V3SP2K</td>
<td>1 mild</td>
<td>1 mild</td>
<td>1 mild</td>
<td>1 mild</td>
<td>1 mild</td>
</tr>
<tr>
<td>V3SP3K</td>
<td>2 moderate</td>
<td>2 moderate</td>
<td>2 moderate</td>
<td>2 moderate</td>
<td>2 moderate</td>
</tr>
<tr>
<td>V3SP4K</td>
<td>3 severe</td>
<td>3 severe</td>
<td>3 severe</td>
<td>3 severe</td>
<td>3 severe</td>
</tr>
<tr>
<td>V3SP5K</td>
<td>4 extreme</td>
<td>4 extreme</td>
<td>4 extreme</td>
<td>4 extreme</td>
<td>4 extreme</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 don't do</td>
<td>5 don't do</td>
</tr>
</tbody>
</table>

V3KOOSSP
# MOST 60-MONTH FOLLOW-UP CLINIC VISIT

## PROCEDURE CHECKLIST

<table>
<thead>
<tr>
<th>Visit</th>
<th>MOST ID #</th>
<th>Acrostic</th>
<th>Date Form Completed</th>
<th>Staff ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>84-month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Page #</th>
<th>Completed</th>
<th>Partially completed</th>
<th>Participant refused</th>
<th>Not done/Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was Self-administered Home Questionnaire completed/checked?</td>
<td>V3HOME</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Was Self-administered Clinic Questionnaire completed/checked?</td>
<td>V3CLIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Was Clinic Interview administered?</td>
<td>V3INTV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Medication Inventory</td>
<td>V3MIF</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Cognitive Screen</td>
<td>V3COGN</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Blood Pressure</td>
<td>V3BP</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Standing Height</td>
<td>V3STAND</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Weight</td>
<td>V3WKHT</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. 20-meter Walk</td>
<td>V320M</td>
<td>34</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Chair Stands</td>
<td>V3CHAIR</td>
<td>36</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Isokinetic Strength / sEMG</td>
<td>V3ISO</td>
<td>39</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Rapid Step Ups</td>
<td>V3RAPDC</td>
<td>45</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Maximal Step Length</td>
<td>V3MAXSL</td>
<td>47</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Gaitante</td>
<td>V3GAIT</td>
<td>49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Plantar Pressure</td>
<td>V3PRES</td>
<td>52</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. VPT &amp; Pain Sensitivity Exclusions</td>
<td>V3VTX</td>
<td>55</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Peripheral Neuropathy</td>
<td>V3PNUM</td>
<td>57</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Vibration Perception Threshold</td>
<td>V3VPB</td>
<td>58</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Pain Sensitivity</td>
<td>V3PSEN</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Knee X-ray</td>
<td>V3KXRAY</td>
<td>66</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. OrthOne 1.0 T Knee MRI</td>
<td>V3MRI1</td>
<td>67</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Initial Pain &amp; Urine collection</td>
<td>V3UR</td>
<td>72</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Phlebotomy</td>
<td>V3SC</td>
<td>73</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Laboratory processing</td>
<td>V3LAB</td>
<td>74</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Accelerometry</td>
<td>V3ACCEL</td>
<td>75</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Page 1*
## Knee Symptoms

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

**Right Knee**

First I'll ask you about your **right knee**.

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

<table>
<thead>
<tr>
<th>Visit</th>
<th>MOST ID #</th>
<th>Acrostic</th>
<th>Staff ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 60-month</td>
<td>☐ 84-month</td>
<td>☒</td>
<td>☐</td>
</tr>
</tbody>
</table>

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

   | V3KPN12R | 1 | ☐ Yes | ☒ No | ☐ Don't know/Refused |

   Go to Page 6, Question #12.

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

   | V3PN30R | 1 | ☒ Yes | ☐ No | ☐ Don't know/Refused |

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

   | V3KPN30R | 1 | ☒ Yes | ☐ No | ☐ Don't know |

   Go to Page 5, Question #11.
People have told us that they experience different kinds of pain (including aching or discomfort) in their knee. To get a better sense of the different types of knee pain you may experience, we would like to ask you about any "constant pain" (pain you have all the time) separately from any pain that you may experience less often, that is, "pain that comes and goes". The following questions will ask you about the pain that you have experienced in your knee in the past 7 days.

3. In the past 7 days, have you had any pain in or around your right knee?
   - Yes
   - No
   - Don't know/Refused

   Go to Page 5, Question #11.

4. In the past 7 days, have you had constant pain (pain that you have all the time) in or around your right knee?
   - Yes
   - No
   - Don't know/Refused

   Go to Page 4, Question #7.

For each of the following questions, please select the response that best describes, on average, your constant pain in your right knee in the past 7 days.

5. In the past 7 days, how intense has your constant pain in your right knee been?
   (Examiner Note: REQUIRED. Show Card #1.)
   - Not at all
   - Mildly
   - Moderately
   - Severely
   - Extremely
   - Don't know
   - Refused

6. In the past 7 days, how much has your constant pain in your right knee affected your overall quality of life?
   (Examiner Note: REQUIRED. Show Card #1.)
   - Not at all
   - Mildly
   - Moderately
   - Severely
   - Extremely
   - Don't know
   - Refused
Knee Pain

7. In the past 7 days, have you had intermittent pain (pain that comes and goes) in or around your right knee?
   - Yes
   - No
   - Don't know/Refused

For each of the following questions, please select the response that best describes your pain that comes and goes in your right knee on average, in the past 7 days.

8. In the past 7 days, how intense has your most severe pain that comes and goes in your right knee been?
   (Examiner Note: REQUIRED. Show Card #2.)
   - Not at all
   - Mildly
   - Moderately
   - Severely
   - Extremely
   - Don't know
   - Refused

9. In the past 7 days, how frequently has this pain that comes and goes in your right knee occurred?
   (Examiner Note: REQUIRED. Show Card #3.)
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very often
   - Don't know
   - Refused

10. In the past 7 days, how much has your pain that comes and goes in your right knee affected your overall quality of life?
    (Examiner Note: REQUIRED. Show Card #4.)
    - Not at all
    - Mildly
    - Moderately
    - Severely
    - Extremely
    - Don't know
    - Refused
11. When you have right knee pain, where does it usually hurt?  
(Examiner Notes: Have participant mark an x(s) where their right knee hurts. Mark all areas that apply.)
Knee Symptoms

**Left Knee**

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

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

   - **V3KPN12L**
   - Yes
   - No
   - Don't know/Refused

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

   - **V3MNTHL**
   - Yes
   - No
   - Don't know

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

   - **V3PN30L**
   - Yes
   - No
   - Don't know/Refused

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

   - **V3KPN30L**
   - Yes
   - No
   - Don't know
Again, I'm going to ask you about any "constant pain" (pain you have all the time) separately from any pain that you may experience less often, that is, "pain that comes and goes". The following questions will ask you about the pain that you have experienced in your knee in the past 7 days.

14. In the past 7 days, have you had any pain in or around your left knee?
   - Yes
   - No
   - Don't know/Refused
   - Go to Page 9, Question #22.

15. In the past 7 days, have you had constant pain (pain that you have all the time) in or around your left knee?
   - Yes
   - No
   - Don't know/Refused
   - Go to Page 8, Question #18.

For each of the following questions, please select the response that best describes, on average, your constant pain in your left knee in the past 7 days.

16. In the past 7 days, how intense has your constant pain in your left knee been? *(Examiner Note: REQUIRED. Show Card #5.)*
   - Not at all
   - Mildly
   - Moderately
   - Severely
   - Extremely
   - Don't know
   - Refused

17. In the past 7 days, how much has your constant pain in your left knee affected your overall quality of life? *(Examiner Note: REQUIRED. Show Card #5.)*
   - Not at all
   - Mildly
   - Moderately
   - Severely
   - Extremely
   - Don't know
   - Refused
18. In the past 7 days, have you had intermittent pain (pain that comes and goes) in or around your left knee?
   - Yes
   - No
   - Don't know/Refused

Go to Page 9, Question #22.

For each of the following questions, please select the response that best describes your pain that comes and goes in your left knee on average, in the past 7 days.

19. In the past 7 days, how intense has your most severe pain that comes and goes in your left knee been?
   (Examiner Note: REQUIRED. Show Card #6.)
   - Not at all
   - Mildly
   - Moderately
   - Severely
   - Extremely
   - Don't know
   - Refused

20. In the past 7 days, how frequently has this pain that comes and goes in your left knee occurred?
   (Examiner Note: REQUIRED. Show Card #7.)
   - Never
   - Rarely
   - Sometimes
   - Often
   - Very often
   - Don't know
   - Refused

21. In the past 7 days, how much has your pain that comes and goes in your left knee affected your overall quality of life?
   (Examiner Note: REQUIRED. Show Card #8.)
   - Not at all
   - Mildly
   - Moderately
   - Severely
   - Extremely
   - Don't know
   - Refused
22. When you have left knee pain, where does it usually hurt?  
(Examiner Note: Have participant mark an x(s) where their left knee hurts. Mark all areas that apply.)
Knee Symptoms

Both Knees

Now I'll ask you about both knees.

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

- Yes
- No
- Don't know/Refused

23a. On how many days did you limit your activities because of pain, aching, or stiffness?

- Yes
- No
- Don't know

23b. During the past 30 days, have you tried to avoid knee pain or reduce the amount of knee pain by avoiding, changing, or cutting back on any of your normal activities?

- Yes
- No
- Don't know

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 or give way but it doesn't actually do so. That does not count.

24. In the past 12 months, has either of your knees buckled or given way at least once?

- Yes
- No
- Don't know/Refused

Go to Page 12, Question #26.

24a. Which knee buckled or gave way at least once?

- Right knee
- Left knee
- Both knees
- Don't know which knee
25. In the past 3 months, has either of your knees buckled or given way at least once?

- Yes
- No
- Don't know/Refused

Go to Page 12, Question #26.

25a. Which knee buckled or gave way at least once?

- Right knee
- Left knee
- Both knees
- Don't know which knee

25b. Counting all times and both knees, how many times in the past 3 months have your knees buckled? If you are unsure, make your best guess.

(Examiner Note: OPTIONAL. Show Card #9.)

- 1 time
- 2 to 5 times
- 6 to 10 times
- 11 to 24 times
- More than 24 times
- Don't know/Refused

25c. As a result of knee buckling or giving way, did you fall and land on the floor or ground?

- Yes
- No
- Don't know

25d. In general, what were you doing when your knee(s) buckled?

(Examiner Note: Please mark all that apply.)

- Walking
- Going up or down stairs
- Twisting or turning
- Other (Please specify: ____________________________)
- Don't know
Knee Buckling

26. In the past 3 months, has either knee felt like it was shifting, slipping, or going to give way but didn't actually do so?
   - Yes
   - No
   - Don't know/Refused

   Go to Question #27.

26a. Which knees felt like they were shifting, slipping, or going to give way but didn't?
   - Right knee
   - Left knee
   - Both knees
   - Don't know which knee

26b. Counting all times and both knees, how many times did your knee feel like it was shifting, slipping, or going to give way? If you are unsure, make your best guess.
   - 1 time
   - 2 to 5 times
   - 6 to 10 times
   - 11 to 24 times
   - More than 24 times
   - Don't know

27. Because of concern about buckling or "giving way" in your knees, have you changed or limited your usual activities in any way?
   - Yes
   - No
   - Don't know/Refused
Knee Injury

The next two questions are about knee injuries.

Right Knee

28. Since we last contacted you, about 2 years ago, have you injured your right knee badly enough to limit your ability to walk for at least two days?

(Examiner Note: Refer to Data from Prior Visits Report for month/year of last clinic visit or missed visit telephone interview.)

V3LAR 1 Yes 0 No 8 Don’t know/Refused

Left Knee

29. Since we last contacted you, about 2 years ago, have you injured your left knee badly enough to limit your ability to walk for at least two days?

V3LAL 1 Yes 0 No 8 Don’t know/Refused
### Knee Surgery

The next few questions are about knee surgery.

30. Since we last contacted you, about 2 years ago, did you have any surgery in your right knee?

   - [ ] Yes
   - [x] No
   - [ ] Don't know/Refused

Examiner Note: Please complete the Event Notification Form and mark Right Knee Replacement and then go to Question #31e below.

Go to Page 15, Question #32.

31. Since we last contacted you, about 2 years ago, did you have the following types of surgery in your right knee:

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

   - [ ] Yes
   - [ ] No
   - [ ] Don't know

   Examiner Note: Please complete the Event Notification Form and mark Right Knee Replacement and then go to Question #31e below.

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

   - [ ] Yes
   - [ ] No
   - [ ] Don't know

   c. Ligament repair in your right knee?

   - [ ] Yes
   - [ ] No
   - [ ] Don't know

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

   - [ ] Yes
   - [ ] No
   - [ ] Don't know

Examiner Note: Record that participant has metal implants in right knee on the OrthOne 1.0 T form (Page 69, Question #8 in the Follow-up Clinic Visit Workbook), and then proceed to Page 15, Question #32.

32. Are any of the answers for Questions #31a-31e above marked "Yes"?

   - [ ] Yes
   - [ ] No
   - [ ] Don't know

Examiner Note: Record that participant has metal implants in right knee on the OrthOne 1.0 T form (Page 69, Question #8 in the Follow-up Clinic Visit Workbook), and then proceed to Page 15, Question #32.
32. Since we last contacted you, about 2 years ago, did you have any surgery in your left knee?

- [ ] Yes
- [ ] No
- [ ] Don't know/Refused

V3SURGL

Go to Page 16, Question #34.

33. Since we last contacted you, about 2 years ago, did you have the following types of surgery in your left knee:

- a. Arthroscopy (where they put a scope) in your left knee?
  - [ ] Yes
  - [ ] No
  - [ ] Don't know
  
  V3ARTL

- b. Meniscectomy (where they repaired or cut away a torn meniscus or cartilage) in your left knee?
  - [ ] Yes
  - [ ] No
  - [ ] Don't know
  
  V3MENL

- c. Ligament repair in your left knee?
  - [ ] Yes
  - [ ] No
  - [ ] Don't know
  
  V3LIGL

- d. Left knee replacement, where all or part of the joint was replaced?
  - [ ] Yes
  - [ ] No
  - [ ] Don't know
  
  V3KNRL

  **Examiner Note:** Please complete the Event Notification Form and mark Left Knee Replacement and then go to Question #33e below.

- e. Another kind of surgery in your left knee?
  - [ ] Yes
  - [ ] No
  - [ ] Don't know
  
  V3SOTHL

- f. i. Are any of the answers for Questions #33a-33e above marked "Yes"?
  - [ ] Yes
  - [ ] No
  - [ ] Don't know
  
  V3SUMYL

  ii. Do you have any metal implants (such as pins, screws, staples, etc.) in your left knee from this surgery?
  - [ ] Yes
  - [ ] No
  - [ ] Don't know
  
  V3MIMPL

  **Examiner Note:** Record that participant has metal implants in left knee on the OrthOne 1.0 T form (Page 69, Question #8 in the Follow-up Clinic Visit Workbook), and then proceed to Page 16, Question #34.

Go to Page 16, Question #34.
The next few questions are about your hip joints.

**Right Hip**

First I'll ask you about your right hip.

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

*(Examiner Note: REQUIRED - Show Card #10.)*

34a. 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?

*(Examiner Note: REQUIRED - Show Card #10. Please mark all that apply.)*

- V3GRINR 1 Groin/inside leg near hip
- V3OTLGR 1 Outside of leg near hip
- V3FRLGR 1 Front of leg near hip
- V3BUTTR 1 Buttocks
- V3LWBKR 1 Lower back
- V3PNDKR 1 Don't know
Hip Pain

**Left Hip**

Now I'll ask you about your left hip.

35. During the past 30 days, have you had any pain, aching, or stiffness in or around your left hip? This includes pain in the groin and front and sides of the upper thigh. Do not include pain that was only in your lower back or buttocks.  
*(Examiner Note: REQUIRED - Show Card #10.)*

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<tr>
<td>84-month</td>
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</table>

35a. During the past 30 days, have you had pain, aching, or stiffness in your left hip on most days?  
*(Examiner Note: REQUIRED - Show Card #10. Please mark all that apply.)*

Where is this pain, aching, or stiffness located?  
*(Examiner Note: REQUIRED - Show Card #10. Please mark all that apply.)*

- V3GRINL 1 ○ Groin/inside leg near hip
- V3OTLGL 1 ○ Outside of leg near hip
- V3FRLGL 1 ○ Front of leg near hip
- V3BUTTL 1 ○ Buttocks
- V3LWBKL 1 ○ Lower back
- V3PNDKL 1 ○ Don't know
Hip Surgery

36. Since we last contacted you, about 2 years ago, did you have a right hip replacement, where all or part of the joint was replaced?

- Yes
- No
- Don't know/Refused

Examiner Note: Please complete the Event Notification Form and mark Right Hip Replacement.

37. Since we last contacted you, about 2 years ago, did you have a left hip replacement, where all or part of the joint was replaced?

- Yes
- No
- Don't know/Refused

Examiner Note: Please complete the Event Notification Form and mark Left Hip Replacement.

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<tr>
<td>☐ 84-month</td>
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</table>
Knee and Hip Replacements

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<tr>
<td>☐ 84-month</td>
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38. Thinking about your knees or hips that have never been replaced, has a doctor or nurse told you that you need a knee or hip replacement?

☐ Yes  ☐ No  ☐ Don’t know/Refused

Go Question #39.

38a. Has a time been scheduled for that surgery within the next 6 months?

☐ Yes  ☐ No  ☐ Don’t know

39. Based on your understanding of the risks and benefits of hip and knee joint replacement surgery and if your symptoms were severe enough, would you be willing to have total joint replacement surgery for your hips or knees?

(Examiner Note: REQUIRED - Show Card #11.)

☐ No, definitely NOT willing to have surgery
☐ No, probably NOT willing to have surgery
☐ I’m not sure
☐ Yes, probably willing to have surgery
☐ Yes, definitely willing to have surgery
☐ Don’t know/Refused
51. Since we last contacted you, about 2 years ago, have you taken a bisphosphonate medication to treat or prevent osteoporosis or to treat Paget's disease? This includes the following medications: alendronate (Fosamax), risedronate (Actonel), etidronate (Didronel), clodronate, ibandronate (Boniva), pamidronate (Aredia), tiludronate (Skelid), or zoledronate/zoledronic acid (Reclast/Zometa). (Examiner Note: Review Data from Prior Visits Report for previously reported bisphosphonate medication. Refer to Card #22 for pronunciation. Do NOT show card to participants.)

- Yes
- No
- Don't know/Refused

Go to Page 26, Question #52.

51a. For how many years did you take bisphosphonates?
If you are unsure, please make your best guess.

(Examiner Note: Round up year at 6 months. <6 months=0 years, and 6-12 months=1 year.)
Medication History

Now think about the last 6 months.

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

- Yes
- No
- Don't know/Refused

52a. During the past 6 months, have you had an injection of hyaluronic acid (Hyaluronan \textit{pronounced hi-AL-yer-ah-nan}, Hyalgan, Orthovisc, Supartz, or Synvisc) in either of your knees for treatment of your arthritis? These injections are given as a series of 2 to 5 weekly injections.

- Yes
- No
- Don't know

i. In which knee?

- Right knee
- Left knee
- Both knees
- Don't know

52b. During the past 6 months, have you had an injection of steroids (cortisone, corticosteroids) in either of your knees for treatment of your arthritis?

- Yes
- No
- Don't know

i. In which knee?

- Right knee
- Left knee
- Both knees
- Don't know
**Medication History**

Female participants only. Male participants: Skip to Page 28, Question #55.

Now think about the past year.

53. During the past year have you taken Tamoxifen (also called Nolvadex), Raloxifene (also called Evista), or Toremifene (also called Farestin), Anastrozole (also called Arimidex), Exemestane (also called Aromasin), Letrozole (also called Femara), sometimes used to treat or prevent breast or ovarian cancer?

*( Examiner Note: Refer to Card #23 for pronunciation. Do NOT show card to participants.)*

- Yes
- No
- Don't know/Refused

a. When was the last time you took this? If you are unsure, please make your best guess.

*( Examiner Note: REQUIRED: Show Card #24.)*

- Less than 1 month ago
- 1 to 2 months ago
- 3 to 6 months ago
- More than 6 months ago
- Don't know

---

**Pregnancy/Menopause**

54. Have you been through menopause or change of life?

- Yes
- No
- Don't know/Refused

*Review Data from Prior Visits Report.*

If participant is age 55 to 60 years old, administer a pregnancy test.
Medication Use

55. **Not counting multi-vitamins**, are you currently taking Vitamin D alone or combined with calcium?

- Yes
- No
- Don't know/Refused

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

- 100 IU
- 200 to 300 IU
- 400 to 800 IU
- 1000 IU
- 2000 or more IU
- Don't know

**Examiner Note:** STOP interview. Please answer the following question based on your judgment of the participant's responses to this questionnaire.

56. On the whole, how reliable do you think the participant's responses to this questionnaire are?

- Very reliable
- Fairly reliable
- Not very reliable
- Don't know
57. Did the participant bring in or identify ALL prescription that they took during the last 30 days? 
(Examiner Note: REQUIRED: Show Card #25 when asking about duration of use.)

**Medication Inventory Form**

- Total number recorded: [ ] [ ] [ ] [ ] medications
- Arrange for telephone call to complete MIF

**PRESCRIPTION MEDICATIONS**

Record the name of the prescription medicine, frequency of use, and formulation code.

**Formulation code:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>V3NAME</th>
</tr>
</thead>
</table>

- Duration of use: | O < 1 month | O 1 month to < 1 year | O 1 to < 3 years | O 3 to < 5 years | O > 5 years | O Don't know |
- Prescription? | O Yes | O No |
- Frequency? | O As Needed | O Reg |

**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
Cognitive Screen

Examiner Note: Review Data from Prior Visits Report.

1. Is participant 65 years old or older?
   - Yes: Complete cognitive screen. Go to Question #2.
   - No: STOP. Go to next test.

2. I am going to say three words that I will ask you to remember. Now repeat them after I have said all three words.
   - Apple, Table, Penny

   (Examiner Note: Name three objects allowing 1 second to say each. Do not repeat the words for the participant until after the first trial. The participant may give the words in any order. If there are errors on the first trial, repeat the items up to six times until they are learned. Record responses to first attempt below.)

   a. Apple
   b. Table
   c. Penny
   d. Numbers of presentations necessary for the participant to repeat the sequence: [ ] presentations

   Correct/Refused
   Error/Refused

3. How frequently do you need help with remembering to take your medications?
   (Examiner Note: REQUIRED. Show Card #26.)
   - Never (0)
   - Rarely (2)
   - Sometimes (4)
   - Frequently (6)
   - Always (8)
   - Participant takes no medications
   - Don't know/Refused
Cognitive Screen

4. How frequently do you need help with planning a trip for errands?
   *(Examiner Note: REQUIRED. Show Card #26.)*
   - Never (0)
   - Rarely (1)
   - Sometimes (2)
   - Frequently (3)
   - Always (4)
   - Don't know/Refused

5. What three words did I ask you to remember earlier?
   *(Examiner Note: The words may be repeated in any order.)*
   - a. Apple
   - b. Table
   - c. Penny

Scoring

OPTIONAL - Combine score for questions #3, 4, and 5.

Total: ____________ (0 - 18)
Blood Pressure

1. What cuff size was used?
   - V3CUFF: ○ Small ○ Regular ○ Large ○ Thigh

2. What arm was used to take the blood pressure?
   - V3ARM: ○ Right ○ Left
   (Examiner Note: Use the right arm unless there are contraindications.)

Pulse Obliteration Level: Complete only if using a sphygmomanometer.

3. Palpated Systolic
   - V3LEVEL
   + 30 *
   * Add 30 to Palpated Systolic measurements to obtain Maximal Inflation Level.

Maximal Inflation Level ** (MIL)
   - V3MIL
   ** If MIL is ≥ 300 mm Hg, repeat the MIL. If MIL is still ≥ 300 mm Hg, terminate blood pressure measurement.

4. Was blood pressure measurement terminated because MIL is ≥ 300 mm Hg after second reading?
   - V3STOP: ○ Yes ○ No

5. Systolic
   - V3SBP
   Diastolic
   - V3DBP

Examiner Note: If the participant’s blood pressure is greater than 199 mm Hg (systolic) or greater than 109 mm Hg (diastolic), mark "Yes" on Page 39, Question #1 of the Isokinetic Strength - sEMG data collection form.

*Page 32*
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?
   
   (Examiner Note: Refer to the Data from Prior Visits Report.
   If possible, use the same position that was used for the last height measurement.)
   
   ○ Yes  ○ No  V3KYPHO

2. Measurement 1  V3HT1 mm

3. Measurement 2  V3HT2 mm

4. Difference between Measurement 1 & Measurement 2  V3DIFF mm

5. Is the difference between Measurement 1 and Measurement 2 greater than 3 mm?
   
   ○ Yes  ○ No  V3DIFF2

   Complete Measurement 3 and Measurement 4 below.

6. Measurement 3  V3HT3 mm

7. Measurement 4  V3HT4 mm  V3HTSID

Weight

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

V3WGHT • kg  V3BMI  V3WT  V3BMICAT  V3WTSID

• Page 33 •
20-Meter Walk

Directions:

1. "Now we want to measure your usual walking speed over this 20-meter course. You will start behind this line. When you have walked a few steps past the orange cone, I want you to stop. Do not slow down until you have passed the cone."

(Examiner Note: Demonstrate how to walk past cone and stop.)
"Now when I say 'Go,' I want you to walk at your usual walking pace. Any questions?"

"Ready, Go."

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

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
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<tr>
<td>V3STEP1</td>
<td>V3STEP2</td>
</tr>
<tr>
<td>V3WALK1</td>
<td>V3WALK2</td>
</tr>
</tbody>
</table>

- **Done**
- **Participant refused**
- **Not attempted, unable**
- **Attempted, unable to complete**

Stop test. Go to next exam.

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. Be sure to walk a few steps past the cone before slowing down. Ready, Go."

Stop test. Go to next exam.
20-Meter Walk

3. During this test, did you experience any pain in your joints or muscles?
   - Yes
   - No
   - Refused or unable to answer

   a. Where was the pain located?
      
      (Examiner Note: Mark all that apply.)

      - Left side
        - Buttock
        - Hip
        - Thigh
        - Knee
        - Leg
        - Ankle
        - Foot
        - Other (Please specify: ____________)

      - Right side
        - Buttock
        - Hip
        - Thigh
        - Knee
        - Leg
        - Ankle
        - Foot
        - Other (Please specify: ____________)

   b. Did the participant report pain in either knee?
      - Yes
      - No

      Examiner Note: REQUIRED: Show Card #27 and ask participant to . . .

      i. Please rate the knee pain that you had by pointing to the number on this card.

      - 0
      - 1
      - 2
      - 3
      - 4
      - 5
      - 6
      - 7
      - 8
      - 9
      - 10

4. Was the participant using a walking aid, such as a cane?
   - Yes
   - No

Page 35
Chair Stands

Single Chair Stand

Directions:
"This is a test of strength in your legs in which you stand up without using your arms."
(Examiner Note: Demonstrate and say:) "Fold your arms across your chest, like this, and stand when I say 'Go,' keeping your arms in this position. OK?"

"Ready, Go!"

1. Single Chair Stand  V3CHAIR
   - 1O Stands without using arms
   - 4O Rises using arms
   - 7O Participant refused
   - 2O Not attempted, unable
   - 3O Attempted, unable to stand
   
   Go to Repeated Chair Stands on the next page.
   
   Stop test. Go to next exam.

[Table]

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<th>Visit</th>
<th>MOST ID #</th>
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<tr>
<td>○ 84-month</td>
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</tbody>
</table>

*Page 36*
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. V3TR1
   1. Completes 5 stands without using arms V3CTIME1
   2. Attempted, unable to complete
   3. Participant refused
   4. Rises using arms
   2. Not attempted, unable to complete

V3NUM1

Stop test. Go to next exam.

Seconds (Time on stopwatch)

Number completed without using arms
6. Within the past 3 months, have you had back surgery?
   ○ Yes  ○ No  ○ Don't know/Refused
   Do NOT test. STOP. Go to next exam.

7. Within the past 6 weeks, have you had a heart attack?
   ○ Yes  ○ No  ○ Don't know/Refused
   Do NOT test. STOP. Go to next exam.

8. Within the past 6 weeks, have you had cataract surgery?
   ○ Yes  ○ No  ○ Don't know/Refused
   Do NOT test. STOP. Go to next exam.

9. Do you have a hernia in your groin that has not been operated on?
   ○ Yes  ○ No  ○ Don't know/Refused
   Do NOT test. STOP. Go to next exam.

10. Do you have a pacemaker or other implanted device, infusion pump or stimulator?
    ○ Yes  ○ No  ○ Don't know/Refused
    Do NOT administer sEMG test.

11. Do you have an allergy to adhesive or allergy to silver?
    ○ Yes  ○ No  ○ Don't know/Refused
    Do NOT administer sEMG test.

12. Does participant have a skin irritation or wound in the area that the electrodes will be placed?
    ○ Yes  ○ No  ○ Don't know/Refused
    Which thigh has a skin irritation?
    ○ Right  ○ Left  ○ Both thighs
    If no other exclusions administer sEMG test on left thigh.
    If no other exclusions administer sEMG test on right thigh.
    Do NOT administer sEMG test.
13. Was the flexion/extension test performed on the left leg?

a. Was the entire set completed?
   - Yes
   - No

b. What were the highest four torques?
   - Flexion
     - Nm
     - Nm
     - Nm
     - Nm
   - Extension
     - Nm
     - Nm
     - Nm
     - Nm

Did participant achieve at least 81-90 degrees range of motion for all tests?
   - Yes
   - No

How many extension/flexion sets were completed?

14. Were any sEMG sensors placed on the left leg?

   a. Channel 1 - Lateral hamstring, 1K gain default (note in Comment if >1K gain required.)
      - Yes
      - No
      - Comment:

   b. Channel 2 - Medial hamstring, 1K gain default (note in Comment if >1K gain required.)
      - Yes
      - No
      - Comment:

   c. Channel 3 - Lateral quadriceps, 1K gain default (note in Comment if >1K gain required.)
      - Yes
      - No
      - Comment:

   d. Channel 4 - Medial quadriceps, 1K gain default (note in Comment if >1K gain required.)
      - Yes
      - No
      - Comment:
15. Was the sEMG test performed on the left leg?
   - Yes
   - No

   a. Was the entire set completed?
      - Yes
      - No

   b. Did sEMG amplifier signal high noise or signal clipping with an audible beep?
      - Yes
      - No

   c. Why wasn't the test done?
      (Examiner Note: Mark all that apply.)
      - Participant refused
      - Stopped test due to participant discomfort
      - Equipment problems
      - Other (Please specify: ____________________________)

16. During this test, did you experience any pain in your joints or muscles?
   - Yes
   - No
   - Refused or unable to answer

   a. Where was the pain located? (Examiner Note: Mark all that apply.)
      - Left side
        - Buttock
        - Hip
        - Thigh
        - Knee
        - Leg
        - Ankle
        - Foot
        - Other (Please specify: ____________________________)
      - Right leg
        - Buttock
        - Hip
        - Thigh
        - Knee
        - Leg
        - Ankle
        - Foot
        - Other (Please specify: ____________________________)

   b. Did participant report pain in either knee?
      - Yes
      - No

   Examiner Note: REQUIRED: Show Card #27 and ask participant to . . .

   i. Please rate the knee pain that you had by pointing to the number on this card. "0" means "No pain" and "10" means "Worst pain you can imagine."
      - 0
      - 1
      - 2
      - 3
      - 4
      - 5
      - 6
      - 7
      - 8
      - 9
      - 10

   c. Did this pain prevent you from pushing or pulling as hard as you can?
      - Yes
      - No
      - Don't know
### Isokinetic Strength - sEMG

**Visit** | **MOST ID #** | **Acrostic**
---|---|---
- 60-month  |  |  
- 84-month  |  |  

17. Was the flexion/extension test performed on the right leg?  
   - Yes  
   - No

   a. Was the entire set completed?  
      - Yes  
      - No

   b. What were the highest four torques?  
      | Flexion | Extension |
      |----------|-----------|
      | Nm       | Nm        |
      | Nm       | Nm        |
      | Nm       | Nm        |
      | Nm       | Nm        |

   c. Why wasn’t the test done?  
      *(Examiner Note: Mark all that apply.)*  
      - Participant refused
      - Stopped test due to participant discomfort
      - Equipment problems
      - Other *(Please specify:_______)*

18. Were any sEMG sensors placed on the right leg?  
   - Yes  
   - No

   a. Channel 1 - Lateral hamstring, 1K gain default (note in Comment if >1K gain required.)  
      - Yes  
      - No  
      Comment:______________________________

   b. Channel 2 - Medial hamstring, 1K gain default (note in Comment if >1K gain required.)  
      - Yes  
      - No  
      Comment:______________________________

   c. Channel 3 - Lateral quadriceps, 1K gain default (note in Comment if >1K gain required.)  
      - Yes  
      - No  
      Comment:______________________________

   d. Channel 4 - Medial quadriceps, 1K gain default (note in Comment if >1K gain required.)  
      - Yes  
      - No  
      Comment:______________________________

---

*Page 43*
19. Was the sEMG test performed on the right leg?

- Yes
- No

a. Was the entire set completed?

- Yes
- No

How many sEMG sets were completed?

b. Did sEMG amplifier signal high noise or signal clipping with an audible beep?

- Yes
- No

c. Why wasn't the test done?

(Examiner Note: Mark all that apply.)

- Participant refused
- Stopped test due to participant discomfort
- Equipment problems
- Other (Please specify: ____________________________ )

20. During this test, did you experience any pain in your joints or muscles?

- Yes
- No
- Refused or unable to answer

a. Where was the pain located? (Examiner Note: Mark all that apply.)

Left side

- Buttock
- Hip
- Thigh
- Knee
- Leg
- Ankle
- Foot
- Other (Please specify: ______________________ )

Right side

- Buttock
- Hip
- Thigh
- Knee
- Leg
- Ankle
- Foot
- Other (Please specify: ______________________ )

b. Did participant report pain in either knee?

- Yes
- No

Examiner Note: REQUIRED: Show Card #27 and ask participant to . . .

i. Please rate the knee pain that you had by pointing to the number on this card.

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

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

- Yes
- No
- Don’t know
Balance

EXCLUSIONS

1. Do you typically use a cane either around the home or when you go out?
   - Yes
   - No
   - Don't know
   - Refused

   **Examiner Note:** Demonstrate rapid step up and maximal step length tests. Ask participant if they can safely do these tests without their cane.

   - Rapid Step-up
     - Yes
     - No
     - Do NOT administer Rapid Step-up Test.

   - Maximal Step Length
     - Yes
     - No
     - Do NOT administer Maximal Step Length Test.

   **Examiner Note:** If participant can safely do either test without their cane, go to Question #2.

2. Was participant able to stand for 30 seconds?
   - Yes
   - No

   **Examiner Note:** Ask participant to stand, feet together, with eyes open, for 30 seconds:

   - Yes
   - No
   - Go to Question #3.

   - Do NOT administer balance tests.

3. Do you typically wear a knee brace either around the home or when you go out?
   - Yes
   - No
   - Don't know
   - Refused

   **Examiner Note:** Demonstrate rapid step up and maximal step length tests. Ask participant if they can safely do both tests without their knee brace.

   - Yes
   - No
   - Don't know

   Test without knee brace.
   Go to Page 46, Question #4.

   **(Examiner Note: ask participant to put on their knee brace if they have it with them.)**

   b. Is participant wearing their knee brace for testing?
   - Yes
   - No

   - On which side is their knee brace?
     - Right
     - Left
     - Both

   - Go to Page 46, Question #4.

   - Do NOT administer balance tests.
Examiner Note: Describe and demonstrate rapid step up test:

**RIGHT**

4. **Directions:**
   "When I say 'Go' step completely onto the block with your right foot and step down again keeping your left foot on the floor. Be sure to put your foot down completely on the step and on the floor. Keep your arms folded across your chest. Continue stepping up and down with your right foot as rapidly as you can until I say STOP. OK?"
   "Ready, Go!"

   - ○ Done
   - ○ Attempted, lost balance
   - ○ Participant refused
   - ○ Not attempted, unable

   **Steps**

   **Go to Step Test Left.**

**LEFT**

5. **Directions:**
   "When I say 'Go' step completely onto the block with your left foot and step down again keeping your right foot on the floor. Be sure to put your foot down completely on the step and on the floor. Keep your arms folded across your chest. Continue stepping up and down with your left foot as rapidly as you can until I say STOP. OK?"
   "Ready, Go!"

   - ○ Done
   - ○ Attempted, lost balance
   - ○ Participant refused
   - ○ Not attempted, unable

   **Steps**

   **Go to Maximal Step Length.**
**Examiner Note: Describe and demonstrate maximal step length test:**

**RIGHT**

6. **Directions:**
   "Very good, now we will do the real test. You will be doing this two times with each leg. Once again, stand in the box with your toes against the starting line and your arms across your chest. When you do the test, take a step forward with your right foot as far as you can safely go and return in a single step to the starting line. Please do not try to step any further than the blue line. OK?"

   ![Diagram of Maximal Step Length Right](image)

**LEFT**

7. **Directions:**
   "Now we are going to do exactly the same thing with the left leg: Toes on the start line, arms folded, one step as far as you can safely go and return in a single step. Do not try to step any further than the blue line."

   ![Diagram of Maximal Step Length Left](image)
Maximal Step Length - Pain

8. During this test, did you experience any pain in your joints or muscles?
   - Yes
   - No
   - Refused or unable to answer

   a. Where was the pain located?
      
      (Examiner Note: Mark all that apply.)

      | Left side                             | Right side                            |
      |---------------------------------------|---------------------------------------|
      | • Buttock                             | • Buttock                             |
      | • Hip                                 | • Hip                                 |
      | • Thigh                               | • Thigh                               |
      | • Knee                                | • Knee                                |
      | • Leg                                 | • Leg                                 |
      | • Ankle                               | • Ankle                               |
      | • Foot                                | • Foot                                |
      | • Other                               | • Other                               |
      | (Please specify:                      | (Please specify:                      |
      |                                      | )                                     |

   b. Did participant report pain in either knee?
      - Yes
      - No

   Examiner Note: REQUIRED: Show Card #27 and ask participant to...

i. Please rate the knee pain that you had by pointing to the number on this card.
   - 0 1 2 3 4 5 6 7 8 9 10
**GAITrite and Plantar Pressure Exclusions**

**Visit** | MOST ID # | Acrostic | Staff ID#
---|---|---|---
☐ 60-month | ☐ | ☐ | ☐
☐ 84-month

(Examiner Note: Do not ask this question.)

1. Is participant using a walker or crutches?
   - ☐ Yes
   - ☐ No

   **Do NOT administer GAITrite or plantar pressure walk tests. Go to next test.**

2. Does participant have a cane with them?
   - ☐ Yes
   - ☐ No

   **a.** When you leave your home, do you use a cane more than half the time when you walk?
   - ☐ Yes
   - ☐ No
   - ☐ Don’t know

   **Do NOT administer GAITrite or plantar pressure walk tests. Go to next test.**

   **b.** Are you able to walk safely over short distances without using a cane?
   - ☐ Yes
   - ☐ No
   - ☐ Don’t know

   **Do NOT administer GAITrite or plantar pressure walk tests. Go to next test.**

3. Is the participant wearing an orthotic knee brace?
   (Examiner Note: Do not include neoprene sleeve or patellar tendon strap.)
   - ☐ Yes
   - ☐ No

   **a.** When you leave your home, do you use a knee brace more than half the time when you walk?
   - ☐ Yes
   - ☐ No
   - ☐ Don’t know

   **Do NOT administer GAITrite or plantar pressure walk tests. Go to next test.**

   **b.** Are you able to walk safely over short distances without using a knee brace?
   - ☐ Yes
   - ☐ No
   - ☐ Don’t know

   **Do NOT administer GAITrite or plantar pressure walk tests. Go to next test.**
Examiner Note: Observe participant for signs of impairment of vision, gait, and balance, or severe joint pain that might pose a safety risk for the GAITrite and plantar pressure tests. If there is a safety concern, ask the participant if they feel they can safely walk short distances. If necessary describe the tests in more detail.
1. In the past 6 weeks, have you been in the hospital overnight or longer for a heart or lung condition?
   - Yes
   - No
   - Don't know/Refused
   
   **Do NOT administer GAITrite walk test. Go to plantar pressure test.**

2. Was the normal-pace walk test administered?
   - Yes
   - No

3. Was the fast-pace walk test administered?
   - Yes
   - No

4. During this test, did you experience any pain in your joints or muscles?
   - Yes
   - No
   - Refused or unable to answer

   a. Where was the pain located?
      **(Examiner Note: Mark all that apply.)**
      
      **Left side**
      - Buttock
      - Hip
      - Thigh
      - Knee
      - Leg
      - Ankle
      - Foot
      - Other (Please specify: )

      **Right side**
      - Buttock
      - Hip
      - Thigh
      - Knee
      - Leg
      - Ankle
      - Foot
      - Other (Please specify: )

   b. Was the pain typical of what you usually feel during this kind of activity?
      - Yes
      - No
      - Refused or unable to answer

      **(Examiner Note: See list of areas with pain above. Do not ask the next question.)**

   c. Did the participant report pain in either knee?
      - Yes
      - No

   **Show Card #27 and ask participant:**

   i. Please rate the knee pain that you had by pointing to the number on this card.
      
      O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10
Examiner Note: Perform bend, twist, and pinch test on participant’s shoe (left preferred).

1. Record type of shoe participant wore to clinic:

   **1a. Bend test**
   - Rigid (no bend)
   - Supportive (bend in toe box; no bend in arch)
   - Flexible (arch bends)
   - Not tested/Other

   **1b. Twist test**
   - Rigid (no twist)
   - Supportive (toe box twists <45 degrees)
   - Flexible (toe box twists >45 degrees)
   - Not tested/Other

   **1c. Pinch test**
   - Rigid (no narrowing of heel counter)
   - Supportive (heel counter narrows - NO medial/lateral contact)
   - Flexible (heel counter narrows - medial/lateral contact)
   - No heel counter present
   - Not tested/Other

2. Does participant have an insert in their right shoe?
   - Yes
   - No

   **2a. What sort of insert?**
   - Supportive
   - Cushioning
   - Both supportive and cushioning
   - Other
   - Not tested

3. Does participant have an insert in their left shoe?
   - Yes
   - No

   **3a. What sort of insert?**
   - Supportive
   - Cushioning
   - Both supportive and cushioning
   - Other
   - Not tested
### Plantar Pressure

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</table>

**Examiner Note: Look at the bottom of the participant’s feet.**

4. Does the participant have any open wounds on the bottom of either of their feet?
   - ☐ Yes
   - ☐ No
   - ☐ Don’t know/Refused

   Do NOT administer plantar pressure walk test. Go to next test.

5. Was the seated foot photograph acquired?
   - ☐ Yes
   - ☐ No

6. Were any walking trials performed?
   - ☐ Yes
   - ☐ No

7. Was standing photograph acquired?
   - ☐ Yes
   - ☐ No

8. Was posture data collected?
   - ☐ Yes
   - ☐ No
9. During the walking part of this test, did you experience any pain in your joints or muscles?
   ○ Yes   ○ No   ○ Refused or unable to answer

   a. Where was the pain located?
      (Examiner Note: Mark all that apply.)

      **Left side**
      ○ Buttock
      ○ Hip
      ○ Thigh
      ○ Knee
      ○ Leg
      ○ Ankle
      ○ Foot
      ○ Other (Please specify: )

      **Right side**
      ○ Buttock
      ○ Hip
      ○ Thigh
      ○ Knee
      ○ Leg
      ○ Ankle
      ○ Foot
      ○ Other (Please specify: )

   b. Was the pain typical of what you usually feel during this kind of activity?
      ○ Yes   ○ No   ○ Refused or unable to answer
      (Examiner Note: See list of areas with pain above. Do not ask the next question.)

   c. Did the participant report pain in either knee?
      ○ Yes   ○ No

   Show Card #27 and ask participant:

   i. Please rate the knee pain that you had by pointing to the number on this card.
      ○ 0   ○ 1   ○ 2   ○ 3   ○ 4   ○ 5   ○ 6   ○ 7   ○ 8   ○ 9   ○ 10
VPT & Pain Sensitivity Exclusions

1. Have you ever had either of your knees replaced?
   - Yes
   - No
   - Don't know/Refused

   a. Which knee was replaced?
      - Right
      - Left
      - Both knees

         Do NOT test R patella.
         Do NOT test L patella.
         Do NOT test R or L patella.

2. Are either of the participant's legs amputated above the knee?
   - Yes
   - No

   a. Which leg was amputated above the knee?
      - Right
      - Left
      - Both legs

         If no other exclusions test left leg.
         If no other exclusions test right leg.
         If no other exclusions test wrist.

3. Are there open or healing skin wounds or surgical scars on the patella or tibial tuberosity?
   - Yes
   - No

   a. Where?
      - Right patella
      - Right tibial tuberosity
      - Left patella
      - Left tibial tuberosity

         Do not test right patella.
         Do not test right tibial tuberosity.
         Do not test left patella.
         Do not test left tibial tuberosity.
VPT & Pain Sensitivity Exclusions

Examiner Note: Ask participant:

4. Have you broken your wrist in the past 6 months?
   - Yes
   - No
   a. Which wrist was broken?
   - Right
   - Left
   - Both wrists
     See if left wrist can be tested.
     See if right wrist can be tested.
     Do not administer vibration perception or pressure pain threshold test on either wrist.

5. Do you regularly wear a splint or brace on your wrist?
   - Yes
   - No
   a. Which wrist?
   - Right
   - Left
   - Both wrists
     See if left wrist can be tested.
     See if right wrist can be tested.
     Do not administer vibration perception or pressure pain threshold test on either wrist.

Examiner Note: Look at the participant’s wrists.

6. Is there a cast, other irremovable item covering the skin, open or healing skin wounds, or surgical scars over either wrist?
   - Yes, right wrist
   - Yes, left wrist
   - No
     See if left wrist can be tested.
     See if right wrist can be tested.

Examiner Note: Look at participant’s right wrist.

7. Is there any other reason that the participant’s right wrist cannot be tested?
   - Yes
   - No
   a. Can the left wrist be tested?
   - Yes
   - No
     Test left wrist.
     Do not perform vibration perception, pressure pain threshold, or pain sensitivity tests on either wrist.
Peripheral Neuropathy, 10 g von Frey filament

Examiner Note. Apply the filament 10 times perpendicularly and briefly, (<1 second) with an even pressure. Instruct participant: "Please say 'now' every time you feel this bristle touch your skin."

RIGHT TOE
1. Was right toe tested?
   - Yes
   - No, unable to test
   - Refused

   a. Was the entire set completed?
      - Yes
      - No

      i. How many trials were completed? [ ] trials

   b. How many times did the participant NOT respond to the stimulus? [ ] times

LEFT TOE
2. Was left toe tested?
   - Yes
   - No, unable to test
   - Refused

   a. Was the entire set completed?
      - Yes
      - No

      i. How many trials were completed? [ ] trials

   b. How many times did the participant NOT respond to the stimulus? [ ] times
Examiner #1 indicates to Examiner #2 with a nod or “ok” that they are ready to begin increasing voltage.

After confirmation, Examiner #2 increases voltage gradually by turning dial clockwise continuously one volt per second by counting “one one thousand, two one thousand, etc.”

As soon as the participant vocalizes feeling the vibration, Examiner #2 should take their hand off the dial.

Read number of volts set on the machine and record onto the data collection form (Trial #1). This should be recorded to the nearest 0.5 volts. If the reading is in-between two numbers, round up.

Continue to Trial #2, etc.

### Vibration Perception Threshold

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### Examiner #1 (applicator)

<table>
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<tr>
<th>Staff ID#</th>
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### Examiner #2 (voltage knob)

<table>
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<th>Staff ID#</th>
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#### RIGHT TIBIAL TUBEROSITY, participant supine, leg straightened out

<table>
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<tr>
<th>Trial</th>
<th>Difference between Trial 1 &amp; Trial 2</th>
<th>Is the difference between Trial 1 and Trial 2 greater than 6 volts?</th>
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<td>Trial 1</td>
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<td>8.</td>
<td>Trial 2</td>
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<td>9.</td>
<td>Difference between Trial 1 &amp; Trial 2</td>
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<td></td>
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<td>10.</td>
<td>Is the difference between Trial 1 and Trial 2 greater than 6 volts?</td>
<td>Yes</td>
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<td>Complete Trials 3 and 4 below. Go to Item #7.</td>
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#### RIGHT RADIAL STYLOID, hand flat on table

<table>
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<th>Is the difference between Trial 1 and Trial 2 greater than 4 volts?</th>
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<td>15.</td>
<td>Difference between Trial 1 &amp; Trial 2</td>
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<tr>
<td>16.</td>
<td>Is the difference between Trial 1 and Trial 2 greater than 4 volts?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complete Trials 3 and 4 below. Go to Item #19.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trial</th>
<th>Difference between Trial 1 &amp; Trial 2</th>
<th>Is the difference between Trial 1 and Trial 2 greater than 4 volts?</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.</td>
<td>Trial 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Trial 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Examiner #1 indicates to Examiner #2 with a nod or “ok” that they are ready to begin increasing voltage.

- After confirmation, Examiner #2 increases voltage gradually by turning the dial clockwise continuously one volt per second by counting “one thousand, two thousand, etc.”

- As soon as the participant vocalizes feeling the vibration, Examiner #2 should take their hand off the dial.

- Read number of volts set on the machine and record onto the data collection form (Trial #1). This should be recorded to the nearest 0.5 volts. If the reading is in-between two numbers, round up.

- Continue to Trial #2, etc.

<table>
<thead>
<tr>
<th>LEFT 1st MTP, participant supine, foot flat on table</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Trial 1</td>
</tr>
<tr>
<td>20. Trial 2</td>
</tr>
<tr>
<td>21. Difference between Trial 1 &amp; Trial 2</td>
</tr>
<tr>
<td>22. Is the difference between Trial 1 and Trial 2 greater than 4 volts?</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

- Complete Trials 3 and 4 below. Go to Item #25.

<table>
<thead>
<tr>
<th>LEFT TIBIAL TUBEROSITY, participant supine, leg straightened out</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Trial 1</td>
</tr>
<tr>
<td>26. Trial 2</td>
</tr>
<tr>
<td>27. Difference between Trial 1 &amp; Trial 2</td>
</tr>
<tr>
<td>28. Is the difference between Trial 1 and Trial 2 greater than 6 volts?</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

- Complete Trials 3 and 4 below. Go to Item #25.

- Complete Trials 3 and 4 below. Go to next test.

<table>
<thead>
<tr>
<th>LEFT RADIAL STYLOID, hand flat on table</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Trial 3</td>
</tr>
<tr>
<td>30. Trial 4</td>
</tr>
<tr>
<td>31. Trial 1</td>
</tr>
<tr>
<td>32. Trial 2</td>
</tr>
<tr>
<td>33. Difference between Trial 1 &amp; Trial 2</td>
</tr>
<tr>
<td>34. Is the difference between Trial 1 and Trial 2 greater than 4 volts?</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

- Complete Trials 3 and 4 below. Go to next test.
### Pain Sensitivity - Touch, 2 g von Frey filament

<table>
<thead>
<tr>
<th>Visit</th>
<th>MOST ID #</th>
<th>Acrostic</th>
<th>Staff ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 60-month</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ 84-month</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 1. DISTAL RADIAL-ULNAR JOINT
(Right preferred)

Please say "now" when you feel this bristle touch your skin, or say "pain" if it was painful.

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
</tbody>
</table>

a. Did the participant report pain at least three times? *(Examiner Note: See Trials 1, 2, 3, and 4 above.)*

- Yes
- No

Ask participant:

i. Please rate the pain at your wrist from this test.

<table>
<thead>
<tr>
<th>Pain Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### 2. RIGHT PATELLA

Please say "now" or "pain."

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
</tbody>
</table>

a. Did the participant report pain at least three times? *(Examiner Note: See Trials 1, 2, 3, and 4 above.)*

- Yes
- No

Ask participant:

i. Please rate the pain at your knee from this test.

<table>
<thead>
<tr>
<th>Pain Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### 3. RIGHT TIBIAL TUBEROSITY

Please say "now" or "pain."

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
</tbody>
</table>

a. Did the participant report pain at least three times? *(Examiner Note: See Trials 1, 2, 3, and 4 above.)*

- Yes
- No

Ask participant:

i. Please rate the pain at your knee from this test.

<table>
<thead>
<tr>
<th>Pain Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### 4. LEFT PATELLA

Please say "now" or "pain."

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
</tbody>
</table>

a. Did the participant report pain at least three times? *(Examiner Note: See Trials 1, 2, 3, and 4 above.)*

- Yes
- No

Ask participant:

i. Please rate the pain at your knee from this test.

<table>
<thead>
<tr>
<th>Pain Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### 5. LEFT TIBIAL TUBEROSITY

Please say "now" or "pain."

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
<tr>
<td>☐ Now</td>
<td>☐ Pain</td>
<td>☐ NR</td>
<td></td>
</tr>
</tbody>
</table>

a. Did the participant report pain at least three times? *(Examiner Note: See Trials 1, 2, 3, and 4 above.)*

- Yes
- No

Ask participant:

i. Please rate the pain at your knee from this test.

<table>
<thead>
<tr>
<th>Pain Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Pain Sensitivity - Touch, 26 g von Frey filament

1. DISTAL RADIAL-ULNAR JOINT
   (Right preferred)
   Please say "now" or say "pain."  ○ Test not done

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
</tbody>
</table>

a. Did the participant report pain at least three times?  (Examiner Note: See Trials 1, 2, 3, and 4 above.)  ○ Yes  ○ No
   Ask participant:
   i. Please rate the pain at your wrist from this test.
      0  1  2  3  4  5  6  7  8  9  10

2. RIGHT PATELLA
   Please say "now" or say "pain."  ○ Test not done

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
</tbody>
</table>

a. Did the participant report pain at least three times?  (Examiner Note: See Trials 1, 2, 3, and 4 above.)  ○ Yes  ○ No
   Ask participant:
   i. Please rate the pain at your knee from this test.
      0  1  2  3  4  5  6  7  8  9  10

3. RIGHT TIBIAL TUBEROSITY
   Please say "now" or say "pain."  ○ Test not done

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
</tbody>
</table>

a. Did the participant report pain at least three times?  (Examiner Note: See Trials 1, 2, 3, and 4 above.)  ○ Yes  ○ No
   Ask participant:
   i. Please rate the pain at your knee from this test.
      0  1  2  3  4  5  6  7  8  9  10

4. LEFT PATELLA
   Please say "now" or say "pain."  ○ Test not done

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
</tbody>
</table>

a. Did the participant report pain at least three times?  (Examiner Note: See Trials 1, 2, 3, and 4 above.)  ○ Yes  ○ No
   Ask participant:
   i. Please rate the pain at your knee from this test.
      0  1  2  3  4  5  6  7  8  9  10

5. LEFT TIBIAL TUBEROSITY
   Please say "now" or say "pain."  ○ Test not done

<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
<tr>
<td>○ Now</td>
<td>○ Pain</td>
<td>○ NR</td>
<td>○ Now</td>
</tr>
</tbody>
</table>

a. Did the participant report pain at least three times?  (Examiner Note: See Trials 1, 2, 3, and 4 above.)  ○ Yes  ○ No
   Ask participant:
   i. Please rate the pain at your knee from this test.
      0  1  2  3  4  5  6  7  8  9  10
# Pain Sensitivity - Temporal summation

**1. DISTAL RADIUS-ULNAR JOINT (right preferred)**

*Say to participant:* Please rate any pain you may have had at your wrist from this test.

- **a.**
  - Pain rating score: 0 0 0 0 0 0 0 0 0 0
  - Test not done
  - If pain rating score is greater than "0": Was that painful?  i. Yes  No  Don't know

*30-sec test*  
*Say to participant:* Please rate the maximal pain you may have experienced at your wrist from this test.

- **b.**
  - Pain rating score: 0 0 0 0 0 0 0 0 0 0
  - Test not done
  - If pain rating score is greater than "0": Was that painful?  i. Yes  No  Don't know

*15-seconds after test*  
*Say to participant:* Please rate any pain you may be experiencing currently at your wrist.

- **c.**
  - Pain rating score: 0 0 0 0 0 0 0 0 0 0
  - Test not done
  - If pain rating score is greater than "0": Is that painful to you?  i. Yes  No  Don't know

**2. RIGHT PATELLA**

*Say to participant:* Please rate any pain you may have had at your knee from this test.

- **a.**
  - Pain rating score: 0 0 0 0 0 0 0 0 0 0
  - Test not done
  - If pain rating score is greater than "0": Was that painful?  i. Yes  No  Don't know

*30-sec test*  
*Say to participant:* Please rate the maximal pain you may have experienced at your knee from this test.

- **b.**
  - Pain rating score: 0 0 0 0 0 0 0 0 0 0
  - Test not done
  - If pain rating score is greater than "0": Was that painful?  i. Yes  No  Don't know

*15-seconds after test*  
*Say to participant:* Please rate any pain you may be experiencing currently at your knee.

- **c.**
  - Pain rating score: 0 0 0 0 0 0 0 0 0 0
  - Test not done
  - If pain rating score is greater than "0": Is that painful to you?  i. Yes  No  Don't know

**3. LEFT PATELLA**

*Say to participant:* Please rate any pain you may have had at your knee from this test.

- **a.**
  - Pain rating score: 0 0 0 0 0 0 0 0 0 0
  - Test not done
  - If pain rating score is greater than "0": Was that painful?  i. Yes  No  Don't know

*30-sec test*  
*Say to participant:* Please rate the maximal pain you may have experienced at your knee from this test.

- **b.**
  - Pain rating score: 0 0 0 0 0 0 0 0 0 0
  - Test not done
  - If pain rating score is greater than "0": Was that painful?  i. Yes  No  Don't know

*15-seconds after test*  
*Say to participant:* Please rate any pain you may be experiencing currently at your knee.

- **c.**
  - Pain rating score: 0 0 0 0 0 0 0 0 0 0
  - Test not done
  - If pain rating score is greater than "0": Is that painful to you?  i. Yes  No  Don't know

---

*Examiner Note: Page 63 has been removed from the Follow-up Visit Workbook.*
Pain Sensitivity - Pinprick

1. **DISTAL RADIAL-ULNAR JOINT**  
   (Right preferred)  
   Please say "now" each time you feel this pin touch your skin, or say "pain" if it was painful.  
<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now</td>
<td>Pain</td>
<td>NR</td>
<td>Yes</td>
</tr>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>Yes</td>
</tr>
</tbody>
</table>
   a. Did the participant report pain at least three times? *(Examiner Note: See Trials 1, 2, 3, and 4 above.)*  
   Yes    No    
   Ask participant:  
   i. Please rate the pain at your wrist from this test.  
      | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

2. **RIGHT PATELLA**  
   Please say "now" or say "pain."  
<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now</td>
<td>Pain</td>
<td>NR</td>
<td>Yes</td>
</tr>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>Yes</td>
</tr>
</tbody>
</table>
   a. Did the participant report pain at least three times? *(Examiner Note: See Trials 1, 2, 3, and 4 above.)*  
   Yes    No    
   Ask participant:  
   i. Please rate the pain at your knee from this test.  
      | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

3. **RIGHT TIBIAL TUBEROSITY**  
   Please say "now" or say "pain."  
<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now</td>
<td>Pain</td>
<td>NR</td>
<td>Yes</td>
</tr>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>Yes</td>
</tr>
</tbody>
</table>
   a. Did the participant report pain at least three times? *(Examiner Note: See Trials 1, 2, 3, and 4 above.)*  
   Yes    No    
   Ask participant:  
   i. Please rate the pain at your knee from this test.  
      | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

4. **LEFT PATELLA**  
   Please say "now" or say "pain."  
<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now</td>
<td>Pain</td>
<td>NR</td>
<td>Yes</td>
</tr>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>Yes</td>
</tr>
</tbody>
</table>
   a. Did the participant report pain at least three times? *(Examiner Note: See Trials 1, 2, 3, and 4 above.)*  
   Yes    No    
   Ask participant:  
   i. Please rate the pain at your knee from this test.  
      | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

5. **LEFT TIBIAL TUBEROSITY**  
   Please say "now" or say "pain."  
<table>
<thead>
<tr>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
<th>Trial 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Now</td>
<td>Pain</td>
<td>NR</td>
<td>Yes</td>
</tr>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>Yes</td>
</tr>
</tbody>
</table>
   a. Did the participant report pain at least three times? *(Examiner Note: See Trials 1, 2, 3, and 4 above.)*  
   Yes    No    
   Ask participant:  
   i. Please rate the pain at your knee from this test.  
      | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
# Pressure Pain Threshold

<table>
<thead>
<tr>
<th></th>
<th>SUPINE - ARM</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Distal radial-ulnar joint, right preferred</td>
<td>Trial 1</td>
<td>Trial 2</td>
<td>Trial 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Test not done</td>
<td>Test not done</td>
<td>Test not done</td>
<td></td>
</tr>
<tr>
<td></td>
<td>kg</td>
<td>kg</td>
<td>kg</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>SUPINE - LEGS</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Right patella</td>
<td>Trial 1</td>
<td>Trial 2</td>
<td>Trial 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Test not done</td>
<td>Test not done</td>
<td>Test not done</td>
<td></td>
</tr>
<tr>
<td></td>
<td>kg</td>
<td>kg</td>
<td>kg</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Right tibial tuberosity</th>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Test not done</td>
<td>Test not done</td>
<td>Test not done</td>
</tr>
<tr>
<td></td>
<td>kg</td>
<td>kg</td>
<td>kg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Left patella</th>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Test not done</td>
<td>Test not done</td>
<td>Test not done</td>
</tr>
<tr>
<td></td>
<td>kg</td>
<td>kg</td>
<td>kg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Left tibial tuberosity</th>
<th>Trial 1</th>
<th>Trial 2</th>
<th>Trial 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Test not done</td>
<td>Test not done</td>
<td>Test not done</td>
</tr>
<tr>
<td></td>
<td>kg</td>
<td>kg</td>
<td>kg</td>
</tr>
</tbody>
</table>
1. Confirm that this is the correct participant: Ask their name, confirm in chart that the name matches the MOST ID# and Acrostic at the top of this form.

2. Were X-rays taken?  
   - Yes
   - No

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

4. Please indicate which views were taken and the settings used.
   a. PA semiflexed view of right and left knee?
      - Yes
      - No

   b. Lateral view of right knee?
      - Yes
      - No

   c. Lateral view of left knee?
      - Yes
      - No

   d. Full limb view?
      - Yes
      - No
OrthOne 1.0 T Knee MRI

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

1. Was participant eligible for MRI at time of Follow-up Telephone Interview? (Examiner Note: Refer to Data from Prior Visits Report)
   - O Yes
   - O No

   Not eligible for MRI. Go to Page 69, Question #9, and mark "No."

2. Does participant weigh > 350 lbs (>159.1 kg)? (Examiner Note: Do not re-weigh participant. Check weight measurement on page 33 in the Follow-up Clinic Visit Workbook.)
   - O Yes
   - O No

   Not eligible for MRI. Go to Page 69, Question #9, and mark "No."

3. Have you had any surgery in the past 2 months?
   - O Yes
   - O No
   - O Don't know

   3a. What type of surgery was it?
   - Go to Page 68, Question #4.

   3b. Does the surgery require a 2-month wait before an MRI can be performed? (Examiner Note: Refer to the list of MRI-safe surgeries/procedures that do not require a 2-month wait. If the surgery or procedure does not require a 2-month wait, mark "No".
   - O Yes
   - O No

   Not eligible for MRI at this time. Go to Page 70, Question #11a and #11b, and mark "Participant scheduled for a later date." Schedule MRI for 2 months after surgery date. Complete and scan Pages 68, 69, 70, and 71 when participant returns for MRI.

   *Page 67*
4. The next few questions will be about specific implants. Please tell me whether you currently have any of the following implanted in your body:

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

4a. Examiner Note:
Are any of the above items in Question #4 marked “Yes” or “Don’t Know/Refused”?  
- Yes: Not eligible for MRI. Go to Page 69, Question #9, and mark “No.”

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

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

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

5b. Since your last visit to the MOST clinic, have you had an injury in which metal fragments such as shrapnel, BB, or bullet entered your body?
**OrthOne 1.0 T Knee MRI**

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

6a. Does the participant have medical documentation that shows that it is safe to have an MRI scan? *(Examiner Note: If documentation is not already in the chart, ask participant if they brought medical documentation showing that it is safe to have an MRI.)*
   - O Yes
   - O No

   Place documentation in participant’s chart and have authorized staff person sign here: ____________________________

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

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

   What is the reason?
   ____________________________

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

8. Has the participant had a knee replacement (where all or part of their joint was replaced), or knee surgery with metal implants in either knee? *(Examiner Note: Refer to Data from Prior Visits Report, Page 14, Q#31d and Q#31fii, Page 15, Q#33d and Q#33fii, Page 39, Q4, and Page 55, Q1 in Follow-up Clinic Visit Workbook or ask.)*
   - O Yes
   - O No

   Which knee was replaced or has metal implants?
   - O Right
   - O Left
   - O Both knees

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

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

   Tech. signature: ____________________________

   Go to Page 70, Question #11.

10. Which knee(s) is being scanned? *(Examiner Note: To determine which knee(s) to scan: Scan both knees unless contraindicated - refer to Question #8 above.)*
    - O Right knee
    - O Left knee
    - O Both knees
11. a. Was an MRI obtained of the right knee?

1 ○ Yes  ○ No

**V3ONIR**

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:)_

b. Was an MRI obtained of the left knee?

1 ○ Yes  ○ No

**V3ONIL**

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:)_
OrthOne 1.0 T Knee MRI

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

a. Right knee scan
   i. Was the right knee scan viewed?
      - Yes, No → Reason: ____________________________ → Comment: ____________________________
   ii. Axial
       - Yes, No → Reason: ____________________________ → Comment: ____________________________
   iii. Sagittal
        - Yes, No → Reason: ____________________________ → Comment: ____________________________
   iv. Coronal STIR
       - Yes, No → Reason: ____________________________ → Comment: ____________________________
   v. 3 Point Dixon
      (Examiner Note: Refer to Data From Prior Visits Report to see if 3 Point Dixon should be obtained.)
      - Yes, No → Reason: ____________________________ → Comment: ____________________________

b. Left knee scan
   i. Was the left knee scan viewed?
      - Yes, No → Reason: ____________________________ → Comment: ____________________________
   ii. Axial
       - Yes, No → Reason: ____________________________ → Comment: ____________________________
   iii. Sagittal
        - Yes, No → Reason: ____________________________ → Comment: ____________________________
   iv. Coronal STIR
       - Yes, No → Reason: ____________________________ → Comment: ____________________________
   v. 3 Point Dixon
      (Examiner Note: Refer to Data From Prior Visits Report to see if 3 Point Dixon should be obtained.)
      - Yes, No → Reason: ____________________________ → Comment: ____________________________
**Initial Knee Pain and Urine Collection**

### 1. While you are sitting here now, are you experiencing any pain in your joints or muscles?
- Yes
- No
- Refused or unable to answer

#### a. Where is the pain located? *(Mark all that apply.)*
- Left side
  - Buttock
  - Hip
  - Thigh
  - Knee
  - Leg
  - Ankle
  - Foot
  - Other
  (Please specify: 

- Right side
  - Buttock
  - Hip
  - Thigh
  - Knee
  - Leg
  - Ankle
  - Foot
  - Other
  (Please specify: 

#### b. Did the participant report pain in either knee?
- Yes
- No

**Examiner Note: REQUIRED: Show Card #27 and ask participant to . . .**

#### i. Please rate the knee pain that you have by pointing to the number on this card. “0” means “No pain” and “10” means “Worst pain you can imagine.”
- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

### 2. Has participant had bilateral knee replacement(s)?
- Yes
- No

**Examiner Note: Check Data from Prior Visits Report.**

Do not obtain biospecimens.

### 3. Was a urine specimen obtained?
- Yes
- No

**Go to Question #5 and explain.**

#### a. Which void(s) was collected?

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

- First
- Second
- Third
- Fourth or later

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

#### b. What time was the urine specimen collected?

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

- Hours
- Minutes
- am
- pm

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

i. Date:  

|   |   |   |

ii. Time:  

|   |   | am | pm |

iii. How many hours has participant fasted?  

|   |   |

#### d. Place of urine collection:  

- Home
- Clinic

**Ask participant:**

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

- Hours
- Minutes
- am
- pm

### 5. Comments on urine collection:
Phlebotomy

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

1. Have you ever had an arm graft shunt or port for kidney dialysis?
   - Yes
   - No
   - Don't know/Refused

   Which side?
   - Right
   - Left
   - Both

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

2. Have you ever had a radical mastectomy or other surgery where lymph nodes were removed from your armpit?
   - Yes
   - No
   - Don't know/Refused

   Which side?
   - Right
   - Left
   - Both

   Go to Question #3 and mark "Neither."

3. Which arm(s) can safely be used for phlebotomy? (Examiner Note: Refer to Questions #1 and #2.)
   - Right
   - Left
   - Either
   - Neither

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

4. Have you had an illness in the past week requiring antibiotics, hospitalization, or steroids?
   - Yes
   - No
   - Don't know/Refused

5. Do you bleed or bruise easily?
   - Yes
   - No
   - Don't know/Refused

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

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

8. What is the date and time you last ate or drank anything except water? (Examiner Note: Do not repeat question if already asked for urine collection on same day.)
   - Date:
   - Time:
   - Hour
   - Minutes
   - am
   - pm

9. Was any blood drawn? (Examiner Note: Proceed with the blood draw even if participant has not fasted.)
   - Yes
   - No

   Please describe why not: ____________________________

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

   Tube
   - EDTA
   - Serum
   - Volume
   - 3 - 5 mL
   - 7 - 10 mL
   - Filled to Capacity
   - Yes
   - No

   Time of blood draw:
   - Hours
   - Minutes
   - am
   - pm

10. Comments on phlebotomy:

   ____________________________

   MOST Follow-up
   Clinic Visit Workbook
   MK
Collection Tubes | Cryo # | Vol. | Cap | Condition of cryovial (mark only one)
---|---|---|---|---
#1 EDTA plasma tube
- plasma | 01 | 0.5 | V | O OK | O H | O P | O B | O not filled
- plasma | 02 | 0.5 | V | O OK | O H | O P | O B | O not filled
- plasma | 03 | 0.5 | V | O OK | O H | O P | O B | O not filled

Ending time of EDTA plasma aliquoting: [ ]: [ ] O am O pm

Time at start of serum processing: [ ]: [ ] O am O pm

Collection Tubes | Cryo # | Vol. | Cap | Condition of cryovial (mark only one)
---|---|---|---|---
#2 Serum tube
- serum | 04 | 0.5 | R | O OK | O H | O P | O B | O not filled
- serum | 05 | 0.5 | R | O OK | O H | O P | O B | O not filled
- serum | 06 | 0.5 | R | O OK | O H | O P | O B | O not filled
- serum | 07 | 0.5 | R | O OK | O H | O P | O B | O not filled
- serum | 08 | 0.5 | R | O OK | O H | O P | O B | O not filled
- serum | 09 | 0.5 | R | O OK | O H | O P | O B | O not filled
- serum | 10 | 0.5 | R | O OK | O H | O P | O B | O not filled

Ending time of serum aliquoting: [ ]: [ ] O am O pm

Urine
- urine | 11 | 0.5 | C | O OK | O P | O not filled
- urine | 12 | 0.5 | C | O OK | O P | O not filled
- urine | 13 | 0.5 | C | O OK | O P | O not filled
- urine | 14 | 0.5 | C | O OK | O P | O not filled

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

Bar Code Label
Enter ID from Bar Code label:

• Page 74 •

MOST Follow-up
Clinic Visit Workbook
ML
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. Did the participant receive a StepWatch?
   - Yes
   - No

   Why didn't participant receive a StepWatch?
   (Note: Mark all that apply.)
   - Participant refused
   - Cognitive impairment
   - No device available/schedule problem
   - Participant not reliable
   - Physical/medical problem (Please specify: ___________)
   - Other (Please specify: _______________)

Examiner Note: Ask participant:

3. Will you be doing any water sports, such as swimming or water aerobics during the next week?
   - Yes
   - No
   - Don't know

   Let participant know that they can wear the StepWatch while they engage in water sports. Give participant an extra strap for their StepWatch.

4. Date and time the StepWatch was set to begin recording:
   / / 
   Hours : Minutes
   - am
   - pm

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