

SECTION A: KNEE QUESTIONNAIRE

A healthy joint is not something you are aware of in everyday life. However, even the smallest problems can raise one's awareness of a joint. This means that you think of your joint or have your attention drawn to it. The following questions concern how often you are aware of your affected knee joint in everyday life. Please choose the most appropriate answer for each question.

Are you aware of your knee joint...	Never	Almost never	Seldom	Sometimes	Mostly
1. ... in bed at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. ... when you are sitting on a chair for more than one hour?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. ... when you are walking for more than 15 minutes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. ... when you are taking a bath/shower?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. ... when you are traveling in a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. ... when you are climbing stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. ... when you are walking on uneven ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. ... when you are standing up from a low sitting position?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. ... when you are standing for long periods of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. ... when you are doing house-work or gardening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. ... when you are taking a walk/hiking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. ... when you are doing your favourite sport?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B: QUALITY OF LIFE

Under each heading, please tick the ONE box that best describes your health TODAY

Mobility

- I have no problems in walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

Self Care

- I have no problems with washing or dressing myself
- I have slight problems with washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems with washing or dressing myself
- I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problem doing my usual activities
- I have a slight problem doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

Pain/Discomfort

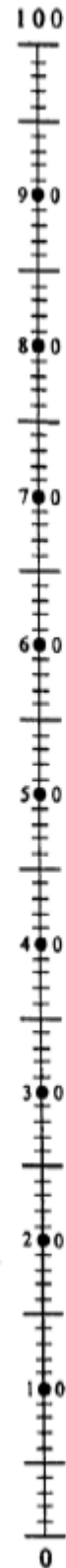
- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

Anxiety/Depression

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

- We would like to know how good or bad your health is **TODAY**.
- This scale is numbered from 0 to 100.
- 100 means the best health you can **imagine**.
- 0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is **TODAY**.
- Now, please write the number you marked on the scale in the box below.

The best health you
can imagine



The worst health you
can imagine

PROBLEMS WITH YOUR KNEE

 Tick (✓) one box for every question.

1. During the past 4 weeks...

 How would you describe the pain you usually have from your knee?

None	Very mild	Mild	Moderate	Severe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. During the past 4 weeks...

 Have you had any trouble with washing and drying yourself (all over) because of your knee?

No trouble at all	Very little trouble	Moderate trouble	Extreme difficulty	Impossible to do
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. During the past 4 weeks...

 Have you had any trouble getting in and out of a car or using public transport because of your knee? (whichever you tend to use)

No trouble at all	Very little trouble	Moderate trouble	Extreme difficulty	Impossible to do
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. During the past 4 weeks...

 For how long have you been able to walk before pain from your knee becomes **severe?** (with or without a stick)

No pain/More than 30 minutes	16 to 30 minutes	5 to 15 minutes	Around the house only	Not at all/pain severe when walking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. During the past 4 weeks...

 After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your knee?

Not at all painful	Slightly painful	Moderately painful	Very painful	Unbearable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. During the past 4 weeks...

 Have you been limping when walking, because of your knee?

Rarely/never	Sometimes, or just at first	Often, not just at first	Most of the time	All of the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. During the past 4 weeks...

Could you kneel down and get up again afterwards?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. During the past 4 weeks...

Have you been troubled by pain from your knee in bed at night?

No nights	Only 1 or 2 nights	Some nights	Most nights	Every night
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. During the past 4 weeks...

How much has pain from your knee interfered with your usual work (including housework)?

Not at all	A little bit	Moderately	Greatly	Totally
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. During the past 4 weeks...

Have you felt that your knee might suddenly 'give way' or let you down?

Rarely/ never	Sometimes, or just at first	Often, not just at first	Most of the time	All of the time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. During the past 4 weeks...

Could you do the household shopping on your own?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. During the past 4 weeks...

Could you walk down one flight of stairs?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Finally, please check back that you have answered each question.
Thank you very much.**

ACTIVITY & PARTICIPATION QUESTIONNAIRE

PLEASE TICK (✓) ONE BOX FOR EACH STATEMENT.

<i>Please consider these statements thinking about the past 4 weeks:</i>	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree
1. It is a problem for me to do activities (e.g. sports, dancing, walking) to the level I want, <u>because of my knee</u>.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. It is a problem for me to carry heavy things (e.g. items at work, shopping, or a child), <u>because of my knee</u>.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I need to modify my work or everyday activities, <u>because of my knee</u>.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I need to plan carefully before going out for the day <u>because of my knee</u> (e.g. taking painkillers, using a knee brace or checking that there will be places to sit down).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. It is a problem for me to fully take part in activities with friends and family, <u>because of my knee</u>.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. It is a problem for me to walk at the pace I would like, <u>because of my knee</u>.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. It is a problem for me to twist or turn, as <u>my knee</u> may give way or be painful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. It is a problem for me that I need to take longer to do everyday activities, <u>because of my knee</u>.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Finally, please check back that you have answered each question.

Thank you very much.

SECTION E: KNEE PAIN

Please respond to each question by marking one box per row.

During the past 7 days...	Had no pain	Mild	Moderate	Severe	Very severe
1. How intense was your pain at its worst?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. How intense was your average pain?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
	No pain	Mild	Moderate	Severe	Very severe
3. What is your level of pain <u>right now</u> ?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

SECTION F: CHANGES IN YOUR KNEE

1. How satisfied you are with your knee replacement? **(Please tick one box only)**

- Very satisfied
- Satisfied
- Neither satisfied nor dissatisfied
- Dissatisfied
- Very dissatisfied

2. **Since your operation** how would you describe the change (if any) in activity limitations, symptoms, emotions and overall quality of life, related to your painful condition ? **(Tick one box only)**

- No change (or condition has got worse)
- Almost the same, hardly any change at all
- A little better, but no noticeable change
- Somewhat better, but the change has not made any real difference
- Moderately better, and slight but noticeable change
- Better, and a definite improvement that has made a real and worthwhile difference
- A great deal better, and a considerable improvement that has made all the difference

SECTION G: PROBLEMS AND COMPLICATIONS

During the past 3 years:

1. Have you had a re-operation or revision of your knee replacement? Yes No

If **YES**, please give details below:

2. Have you had any other treatment or surgery to your knee, apart from the operation you had as part of the study? Yes No

If **YES**, please give details below:

3. Have you had any other injuries to the your knee? Yes No

If **YES**, please give details below

4. Have you had an infection of your knee? Yes No

If **YES**, were you given antibiotics orally, through a vein, or both? Please give details below:

5. Have you been diagnosed with a deep vein thrombosis (DVT) or pulmonary embolism (PE)? Yes No

If **YES**, please give details below:

SECTION H: PAINKILLERS AND ANALGESIA

In this section, we would like to know how much of different pain-killing drugs you are using for your knee on a typical day **over the past 4 weeks**. If you are not taking any pain-killing drugs for your knee, please mark the “No” box below.

1. Are you taking any painkillers or analgesia medicine for your knee in the study?
 Yes, please complete the below tables

 No, please go to **SECTION I**

Common painkillers or analgesia tablets you may be using could include:

- | | |
|--|---|
| <ul style="list-style-type: none"> • Paracetamol (soluble or tablets) • Anti-Inflammatory (Ibuprofen, Naproxen, Diclofenac, Celecoxib etc.) • Co-codamol (Zapain, Solpadol, Tylenol etc.) • Tramadol | <ul style="list-style-type: none"> • Oxycodone/Oxynorm, • Morphine Sulphate Tablets (MST, Morphogesic, Zomorph, Sevredol, MXL etc.) • Gabapentin • Pregabalin |
|--|---|

If you do not know exactly how much medication you have been having, please give us your best guess.

Table 1: TABLETS

Name of Medication <i>Please write the medication name in the blank lines, some examples have been provided in the table above.</i>	Strength of Tablet <i>Please include units (e.g. mg or 8/500 etc.)</i>	Thinking about the <u>last 4 weeks</u>, on a typical day how many tablets did you take in total, per day? <i>For example, if you typically took 2 tablets four times during the day, then write “8” below.</i>
<i>Example: Paracetamol</i>	<i>500mg</i>	<i>8</i>

Table 2: LIQUID

(a usual dose is 5mls = one teaspoon or 10mls = two teaspoons etc.)

Name of Medication <i>Please write the medication name in the blank lines</i>	Strength of Medication <i>Please include units (e.g. mls, teaspoons etc.)</i>	Thinking about the <u>last 4 weeks</u>, on a typical day how many teaspoons did you take in total, per day? <i>(for example, if you take 1 teaspoon (5ml) four times a day, write "4")</i>
<i>Example: Morphine liquid (or Oramorph)</i>	<i>5ml or 1 teaspoon</i>	<i>4</i>

Table 3: PATCHES

Name of Medication <i>Please write the medication name in the blank lines</i>	Strength of Medication <i>Please include units (e.g. mcg)</i>	Thinking about the <u>last 4 weeks</u>, how many patches have you used? <i>Please write number</i>
<i>Example: Morphine patch (Fentanyl patch)</i>	<i>75 mcg</i>	<i>2</i>

SECTION K: COVID-19

The COVID-19 pandemic has affected many people worldwide and we would like to know how many have been affected in this trial:

A. Do you think you have had COVID-19?

No Yes

B. If **YES**, and you think you have had COVID-19, was this confirmed with a test?

No Yes

SECTION L: MOBILE APP

Would you like to complete your future follow-up questionnaires using a mobile app?

No Yes

Thank you for completing this questionnaire.

If you are likely to change your contact details in the next five years, please fill out the “Change of Contact Details Form” on the following page.

Please return this booklet to the RACER Trial Office in the Freepost envelope provided.

Site Code: Participant TNO:

Please let us know about any changes to your contact details, or your additional contacts, please complete the below form and return with your completed questionnaire or contact RACER@warwick.ac.uk

Please note that we will use all contact information you provide to attempt to reach you, unless you specify otherwise.

Your Contact Details:

Date changes effective from: - -

Title: First Name: Surname:

1st Line of Address :

2nd Line of Address:

Town/City: Postcode:

Telephone: Mobile:

Email: Preferred time of contact:

To help us stay in touch with you for the duration of the study, please could you to provide us with updated additional contacts. We will only make contact with these people if we cannot reach you directly. You only need to update these details if the information previously provided is now incorrect.

Please only provide contact information which you have prior permission to share with us.

Additional Contact 1:

Title:

First Name:

Surname:

Email:

Telephone:

Mobile:

Relationship:

Additional Contact 2:

Title:

First Name:

Surname:

Email:

Telephone:

Mobile:

Relationship:

GP Details: *(If changed since entering the Trial)*

Doctors Surgery Name:

Address:

For information on how your, and your additional contacts, identifiable information is handled please contact the RACER Team on the above email address or visit the trial website: <https://warwick.ac.uk/fac/sci/med/research/ctu/trials/current/racer/>