TRIAL OFFICE | *Received:* *Initial:* | *Checked:* *Initial:*

Baseline Form

TNO: ☐☐☐☐☐ Initials: ☐☐☐ Site code: ☐☐☐

KNEE HISTORY

1. Which is the affected knee (knee included in the study)? ☐ Left ☐ Right

2. Duration of symptoms in the affected knee (study knee)?
   - ☐ Less than a year
   - ☐ 1-5 years
   - ☐ 6-10 years
   - ☐ More than 10 years

3. Does the participant have a history of knee intra-articular fracture (i.e. fracture into the joint surface?) ☐ No ☐ Yes

   If Yes, please give approx. date of injury m o n – y y y y

4. Has the participant had a knee replacement on the other knee? ☐ No ☐ Yes

5. Has the participant had previous treatment to the affected knee (study knee)?

   I. Physiotherapy in the last 12 months ☐ **No** ☐ **Yes**

   a) If Yes, is physiotherapy still ongoing? ☐ No ☐ Yes

   II. Steroid injection ☐ **No** ☐ **Yes**

   a) If Yes, total number of injections in the affected knee ☐☐

   b) Date of most recent injection (approx.) m o n – y y y y

   III. Previous surgery ☐ **No** ☐ **Yes**

   If Yes, was it:

   a) Arthroscopy/Meniscal Surgery ☐ No ☐ Yes

   No. of procedures: ☐☐

   Date of most recent procedure: m o n – y y y y

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KNEE HISTORY

III. Previous surgery (cont.)

If Yes, was it:

b) Anterior Cruciate Ligament reconstruction ☐ No ☐ Yes

No. of procedures: ☐☐

Date of most recent procedure: m o n – y y y y

c) Cartilage Regeneration Surgery ☐ No ☐ Yes

No. of procedures: ☐☐

Date of most recent procedure: m o n – y y y y

d) High tibial osteotomy ☐ No ☐ Yes

No. of procedures: ☐☐

Date of most recent procedure: m o n – y y y y

e) Other, please give details: ☐ No ☐ Yes

Type of procedure: ______________________

Date of most recent procedure: m o n – y y y y

MEDICAL IMAGING—available at baseline (copies of previous imaging in an anonymised form will be requested by the trial office)

1. What recent imaging has the participant had of the affected knee?

I. MRI ☐ No ☐ Yes

a) If Yes, please provide most recent date m o n – y y y y

II. X-ray ☐ No ☐ Yes

a) If Yes, please provide most recent date m o n – y y y y

III. CT scan ☐ No ☐ Yes

a) If Yes, please provide most recent date m o n – y y y y

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Baseline Form

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BACKGROUND INFORMATION

1. Please tick the box closest to the participant's ethnic background. (Tick one box only)

White ☐
Mixed/Multiple Ethnic Groups ☐
Asian/Asian British ☐
Black/African/Caribbean/Black British ☐
Other Ethnic Group ☐

2. What is the participant's current employment status? (Tick one box only)

Full-time employed ☐
Unpaid work ☐
Part-time employed ☐
Unemployed ☐
Self-employed ☐
Full time student ☐
Retired ☐
Full time carer ☐

3. Does the participant have a history of any of the medical conditions listed below?

(Please tick all that apply)

Condition	No		Yes	
Myocardial Infarction:	No	☐	Yes	☐
Congestive Heart Failure:	No	☐	Yes	☐
Peripheral Vascular Disease:	No	☐	Yes	☐
Stroke or TIA:	No	☐	Yes	☐
Dementia:	No	☐	Yes	☐
Hemiplegia:	No	☐	Yes	☐
COPD:	No	☐	Yes	☐
Connective Tissue Disease:	No	☐	Yes	☐
Peptic Ulcer Disease:	No	☐	Yes	☐
Liver Disease:	No	☐	Yes	☐
If yes: Mild:	No	☐	Yes	☐
Moderate to Severe:	No	☐	Yes	☐

Baseline Form

TNO: ☐☐☐☐☐ Initials: ☐☐☐ Site code: ☐☐☐

3. Does the participant have a history of any of the medical conditions listed below? (cont.)

(Please tick all that apply)

		No	Yes
Diabetes:		☐	☐
If Yes:	Diet Controlled	☐	☐
	Oral drugs (Tablets)	☐	☐
	Insulin:	☐	☐
Moderate to severe CKD:		☐	☐
Solid Tumour:		☐	☐
If Yes:	Localised	☐	☐
	Metastatic	☐	☐
Leukaemia:		☐	☐
Lymphoma:		☐	☐
AIDS:		☐	☐

4. Does the participant *currently* smoke tobacco products e.g. cigarettes, pipe, cigars?

No ☐ Yes ☐

a) If Yes, how many per week? ☐☐☐

b) And for how many years? ☐☐

5. How many units of alcohol does the participant drink in a normal week? (A **unit** is approximately 1/2 pint of standard strength beer or cider, 1/2 a small 125ml glass of wine or 25ml of standard strength whiskey)

0-7 units ☐ 8-14 units ☐ 15-21 units ☐ More than 21 units ☐

6. Does the participant use a walking aid?

No ☐ Yes ☐

a) If Yes, please detail what walking aid is used:

☐ 1 stick ☐ 2 crutches

☐ 2 sticks ☐ Walking frame

☐ 1 crutch ☐ Wheelchair

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Baseline Form

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EXAMINATION:

1. Affected knee (study knee) range of motion (measured with a goniometer):

Flexion: ☐☐☐ degrees Extension: ☐☐☐ degrees

COVID-19:

1. Has the participant had any symptoms of COVID-19? No ☐ Yes ☐

If Yes, please tick all that apply:
- a) A high temperature ☐
- b) A new continuous cough ☐
- c) A loss or change in sense of smell or taste ☐

2. Has the participant had a positive test for COVID-19? No ☐ Yes ☐

a) If Yes, date sample was taken which returned a positive COVID-19 result

(if multiple, date of most recent positive test) d d - m o n - y y y y

Please note, your name must be on the trial delegation log

Form completed by (print name): ……………………………………………………….

Signature: ………………………………………………………… Date signed: d d - m o n - y y y y