Appendix 1. Patient Survey

Demographics	
What is your name?	
Are you filling this questionnaire out for yourself or your child?	○ My self ○ My child
Was surgery performed on the affected knee?	○ Yes ○ No
On which knee did Dr. XXX or Dr. XXX perform surgery?	○ Left ○ Right ○ Both
2000 IKDC Subjective Knee Evaluation Form	
What is the highest level of activity that you can perform without significant knee pain?	○ Very strenuous activities like jumping or pivoting as in basketball or soccer ○ Strenuous activities like heavy physical work, skiing or tennis ○ Moderate activities like moderate physical work, running or jogging ○ Light activities like walking, housework or yardwork ○ Unable to perform any of the above activities due to knee pain
During the past 4 weeks, or since your injury, how often have you had pain? (0 = Never and 10 = Constant)	□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
If you have pain, how severe is it? (0 = No pain and 10 = worst pain imaginable)	□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
During the past 4 weeks, or since your injury, how stiff or swollen was your knee?	○ Not at all ○ Mildly ○ Moderately ○ Very ○ Extremely
What is the highest level of activity you can perform without significant swelling in your knee?	○ Very strenuous activities like jumping or pivoting as in basketball or soccer ○ Strenuous activities like heavy physical work, skiing or tennis ○ Moderate activities like moderate physical work, running or jogging ○ Light activities like walking, housework or yardwork ○ Unable to perform any of the above activities due to knee pain
During the past 4 weeks, or since your injury, did your knee lock or catch?	○ Yes ○ No

What is the highest level of activity you can perform without significant giving way in your knee?	○ Very strenuous activities like jumping or pivoting as in basketball or soccer ○ Strenuous activities like heavy physical work, skiing or tennis ○ Moderate activities like moderate physical work, running or jogging ○ Light activities like walking, housework or yardwork ○ Unable to perform any of the above activities due to knee pain				
What is the highest level of activity you can participate in on a regular basis?	○ Very strenuous activities like jumping or pivoting as in basketball or soccer ○ Strenuous activities like heavy physical work, skiing or tennis ○ Moderate activities like moderate physical work, running or jogging ○ Light activities like walking, housework or yardwork ○ Unable to perform any of the above activities due to knee pain				
How does your knee affect your ability to:	Not difficult at all	Minimally difficult	Moderately difficult	Extremely difficult	Unable to
a. Go up stairs	□	□	□	□	□
b. Go down stairs	□	□	□	□	□
c. Kneel on the front of your knee	□	□	□	□	□
d. Squat	□	□	□	□	□
e. Sit with your knee bent	□	□	□	□	□
f. Rise from a chair	□	□	□	□	□
g. Run straight ahead	□	□	□	□	□
h. Jump and land on your involved leg	□	□	□	□	□
i. Stop and start quickly	□	□	□	□	□
Function: How would you rate the function of your knee on a scale of 0 to 10 with 10 being normal, excellent function and 0 being the inability to perform any of your usual daily activities which may include sports?					
Function prior to your knee injury: (0 = Cannot perform daily activities and 10 = No limitation in daily activities)	□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10				

Current function of your knee: (0 = Cannot perform daily activities and 10 = No limitation in daily activities)	□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
Marx Activity Scale	
Please indicate how often you performed each activity in your healthiest and most active state, in the past year.	
Running: running while playing a sport or jogging	○ Less than one time in a month ○ One time in a month ○ One time in a week ○ 2 or 3 times in a week ○ 4 or more times in a week
Cutting: changes directions while running	○ Less than one time in a month ○ One time in a month ○ One time in a week ○ 2 or 3 times in a week ○ 4 or more times in a week
Decelerating: coming to a quick stop while running	○ Less than one time in a month ○ One time in a month ○ One time in a week ○ 2 or 3 times in a week ○ 4 or more times in a week
Pivoting: turning your body with your foot planted while playing a sport; For example: skiing, skating, kicking, throwing, hitting a ball (golf, tennis, squash), etc.	○ Less than one time in a month ○ One time in a month ○ One time in a week ○ 2 or 3 times in a week ○ 4 or more times in a week
Survey	
How would you rate your affected knee today as a percentage of normal (0-100% scale with 100% being "normal")?	0% 50% 100%
Please indicate how often you experienced knee instability events (i.e., the feeling of your knee giving way), in the past year?	○ Less than one time in a month ○ One time in a month ○ One time in a week ○ 2 or 3 times in a week ○ 4 or more times in a week
How satisfied are you with the results of your surgery?	○ Very Satisfied ○ Satisfied ○ Neutral ○ Unsatisfied ○ Very Unsatisfied

Looking back, if you "had to do it all over again", would you have the surgery again?	○ Definitely, yes ○ Probably, yes ○ Unsure ○ Probably, no ○ Definitely, no
Have you had any further surgeries on your knee since your initial knee surgery with Dr. XXX or Dr. XXX?*	○ Yes ○ No
Please explain what further surgeries you've had since your initial knee surgery with Dr. XXX or Dr. XXX. Include approximate date of surgery, if known.	□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
Since your knee surgery, have you experienced any other injuries to your surgical knee?*	○ Yes ○ No
Since your knee surgeries, have you experienced any injuries to your other knee?*	○ Yes ○ No
Do you currently play any sports?	○ Yes ○ No
What sports do you currently play and at what level (competitive, recreational, etc)?	(Example: recreational basketball, compeititive soccer)
Are there any sports you would like to play but avoid because of your knee?	○ Yes ○ No
Why do you avoid the activity?	☐ Personal choice ☐ Outside influence (parent, friend, coach, therapist, physician, etc.) ☐ Knee does not tolerate sport ☐ Other (specify below)
Do you notice any stiffness or loss of motion in your knee?	○ Yes ○ No
How would you rate your pain on a scale of 0-10 at rest? (0 = No pain and 10 = worst pain imaginable)	□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
How would you rate your pain on a scale of 0-10 during daily activities?	□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

(0 = No pain and 10 = worst pain imaginable)	
How would you rate your pain on a scale of 0-10 during sport activities? (0 = No pain and 10 = worst pain imaginable)	□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10
*If affirmative, confirmed via chart review.	