

# Additional Patient Reported Outcomes Questions

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## **Instructions:**

Answer each question by marking the most appropriate box, giving only one answer per question.  
If you are unsure how to answer a question, please give the best answer you can.

1. What amount of pain have you experienced in the last week in your other knee/hip?

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

2. My BACK PAIN at the moment is:

None	Very Mild	Moderate	Fairly Severe	Very Severe	Worst Imaginable
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. How comfortable are you filling out medical forms by yourself?

Extremely	Quite a bit	Somewhat	A little bit	Not at all
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>