Patient Study ID Number: __ __ - __ __ __ __ Date of Completion (mm/dd/yy): ___ ___ / ___ ___ / ___ ___

PEPPER

Pulmonary Embolism Prevention after hiP and kneE Replacement

Knee Follow–Up Survey

(For use at the 3 and 6 Month follow–ups)

Since your operation, did any of the following happen?	NO	YES
1. Did you make an unplanned visit to a physician after your operation?	☐	☐
2. Did you make an unplanned visit to an emergency room after your operation?	☐	☐
3. Were you admitted to any hospital since your operation?	☐	☐
4. Did you return to the operating room since your operation?	☐	☐
5. Did your doctor tell you that you had a blood clot in your leg, or a DVT (Deep Vein Thrombosis)?	☐	☐
6. Did your doctor tell you that you had a blood clot in your lungs, or a PE (Pulmonary Embolism)?	☐	☐
7. Did you have any bleeding issues?	☐	☐

8. If "yes" to any of the above, specify the reason for the care, dates, name of hospital/clinics, and whether the care was at the same or a different hospital as your original operation.

Did any of the following happen since your knee replacement?	**NO**	**YES**
9. After the operation, during a visit to the doctor's office, did your surgeon, or any other person, put a needle **in your knee** to remove fluid or blood?	☐	☐
10. After the operation, during a visit to the doctor's office, did your surgeon, or any other person, put a needle **in your incision** to remove fluid or blood?	☐	☐
11. After the sutures or staples from your operation were removed, did your incision leak fluid or blood for more than one day?	☐	☐
12. Did your doctor or anyone else tell you that your knee was infected?	☐	☐
13. Are you currently taking antibiotic medications prescribed by your surgeon or another doctor because of an infection in your knee?	☐	☐
14. Did you have a problem with stiffness of your knee replacement that required another procedure (manipulation) to bend the knee under anesthesia?	☐	☐
15. Did you have a heart attack?	☐	☐

	NO	**YES**
16. Are you currently taking pain medications prescribed by your surgeon or another doctor because of pain in your knee?	☐	☐
16 (a). If you are taking a prescription pain medication for hip pain, is it an opioid- or narcotic-type pain medication? Examples are: hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin, Percocet), morphine (e.g., Kadian, MSContin), codeine, and hydromorphone (e.g. Dilaudid).	☐	☐

The following question concerns the amount of joint stiffness you have experienced during the **last week** in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.

	None	Mild	Moderate	Severe	Extreme
17. How severe is your knee stiffness after first awakening in the morning?	☐	☐	☐	☐	☐

What amount of knee pain have you experienced in the **last week** during the following activities?

	None	Mild	Moderate	Severe	Extreme
18. Twisting/pivoting on your knee	☐	☐	☐	☐	☐
19. Straightening your knee fully	☐	☐	☐	☐	☐
20. Going up or down stairs	☐	☐	☐	☐	☐
21. Standing upright	☐	☐	☐	☐	☐

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your knee?

	None	Mild	Moderate	Severe	Extreme
22. Rising from sitting	☐	☐	☐	☐	☐
23. Bending to floor/pick up an object	☐	☐	☐	☐	☐
24. Putting on shoes/stockings	☐	☐	☐	☐	☐
25. Kneeling	☐	☐	☐	☐	☐
26. Squatting	☐	☐	☐	☐	☐
27. Rising from bed	☐	☐	☐	☐	☐

28. How do you take stairs? *(check one)*

- One at a time ☐
- One after another ☐
- Not applicable, do not take stairs ☐

29. In general, would you say your health is: *(check one)*

- Excellent ☐
- Very Good ☐
- Good ☐
- Fair ☐
- Poor ☐

30. In general, would you say your quality of life is: *(check one)*

- Excellent ☐
- Very Good ☐
- Good ☐
- Fair ☐
- Poor ☐

31. In general, how would you rate your physical health: *(check one)*	Excellent	☐
	Very Good	☐
	Good	☐
	Fair	☐
	Poor	☐
32. In general, how would you rate your mental health, including your mood and your ability to think? *(check one)*	Excellent	☐
	Very Good	☐
	Good	☐
	Fair	☐
	Poor	☐
33. In general, how would you rate your satisfaction with your social activities and relationships? *(check one)*	Excellent	☐
	Very Good	☐
	Good	☐
	Fair	☐
	Poor	☐
34. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.) *(check one)*	Excellent	☐
	Very Good	☐
	Good	☐
	Fair	☐
	Poor	☐
35. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair: *(check one)*	Completely	☐
	Mostly	☐
	Moderately	☐
	A little	☐
	Not at all	☐
36. In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable? *(check one)*	Never	☐
	Rarely	☐
	Sometimes	☐
	Often	☐
	Always	☐
37. In the past 7 days, how would you rate your fatigue on average? *(check one)*	None	☐
	Mild	☐
	Moderate	☐
	Severe	☐
	Very Severe	☐

38. How would you rate your current level of pain?

No Pain				*(Circle Answer)*						**Worst Possible Pain**
0	1	2	3	4	5	6	7	8	9	10

The following questions concern the Coronavirus (COVID-19) pandemic which occurred in early 2020.

	NO	**YES**
39. Have you ever tested positive for COVID-19? 39(a). If yes, when:_____	☐	☐
40. Have you ever been sick with COVID-19? 40(a). If yes, when:_____	☐	☐
41. Was your surgery canceled and rescheduled because of COVID-19?	☐	☐

42. Did you receive a covid-19 vaccine?

- ☐ Yes, Pfizer/BioNTech
- ☐ Yes, Moderna
- ☐ Yes, Johnson & Johnson
- ☐ Yes, AstraZeneca
- ☐ Yes, but not sure which one
- ☐ No, I did not receive a covid-19 vaccine

43. If you received a Covid-19 vaccine, how many doses did you receive? _____

44. If you received a Covid-19 Vaccine, what was the date of your most recent dose: _____

Thank you for your participation in research!