

**Appendix 1. Patient Questionnaire**

PI: \*\*\*

IRB: \*\*\*

Title: Durability of Smoking Cessation for Elective Total Joint Surgery

MRN: \_\_\_\_\_

Name: \_\_\_\_\_

- 1) Did you use tobacco within the year preceding your total joint surgery? (Y/N)
  
- 2) What type of tobacco products did you use?
  
- 3) Did you receive tobacco cessation request prior to your total joint surgery? (Y/N)
  
- 4) How much tobacco did you use preoperatively prior to any cessation efforts?
  
- 5) Were you able to successfully cut back on your tobacco usage prior to surgery? (Y/N)
  - a) If Yes:

- i) How much tobacco did you use preoperatively after cessation efforts?
  
  - ii) How long after your surgery did you sustain from tobacco use?
  
  - iii) What methods did you use to help with tobacco cessation?
- 6) Are you currently using tobacco products on a regular basis (i.e. more than 1 time per month)?  
(Y/N)
- a) If Yes:
    - i) How much tobacco are you currently using?
- 7) Have you had any complications from your joint replacement surgery and what were they?
- 8) Have you had revision surgery on your joint replacement?

The next questions are about the function of your joint replacement:

	Excellent	Very Good	Good	Fair	Poor
1. In general, would you say your health is:	<input type="checkbox"/> +5	<input type="checkbox"/> +4	<input type="checkbox"/> +3	<input type="checkbox"/> +2	<input type="checkbox"/> +1
2. In general, would you say your quality of life is:	<input type="checkbox"/> +5	<input type="checkbox"/> +4	<input type="checkbox"/> +3	<input type="checkbox"/> +2	<input type="checkbox"/> +1
3. In general, how would you rate your physical health?	<input type="checkbox"/> +5	<input type="checkbox"/> +4	<input type="checkbox"/> +3	<input type="checkbox"/> +2	<input type="checkbox"/> +1
4. In general, how would you rate your mental health, including your mood and your ability to think?	<input type="checkbox"/> +5	<input type="checkbox"/> +4	<input type="checkbox"/> +3	<input type="checkbox"/> +2	<input type="checkbox"/> +1
5. In general, how would you rate your satisfaction with your social activities and relationships?	<input type="checkbox"/> +5	<input type="checkbox"/> +4	<input type="checkbox"/> +3	<input type="checkbox"/> +2	<input type="checkbox"/> +1
9r. 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.)	<input type="checkbox"/> +5	<input type="checkbox"/> +4	<input type="checkbox"/> +3	<input type="checkbox"/> +2	<input type="checkbox"/> +1

	Completely	Mostly	Moderately	A little	Not at all
6. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	<input type="checkbox"/> +5	<input type="checkbox"/> +4	<input type="checkbox"/> +3	<input type="checkbox"/> +2	<input type="checkbox"/> +1

	Never	Rarely	Sometimes	Often	Always
10r. How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	<input type="checkbox"/> +5	<input type="checkbox"/> +4	<input type="checkbox"/> +3	<input type="checkbox"/> +2	<input type="checkbox"/> +1

	None	Mild	Moderate	Severe	Very Severe
8r. How would you rate your fatigue on average?	<input type="checkbox"/> +5	<input type="checkbox"/> +4	<input type="checkbox"/> +3	<input type="checkbox"/> +2	<input type="checkbox"/> +1

	No pain										Worst pain imaginable									
7rc. How would you rate your pain on average?	<input type="checkbox"/> +0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3	<input type="checkbox"/> +4	<input type="checkbox"/> +5	<input type="checkbox"/> +6	<input type="checkbox"/> +7	<input type="checkbox"/> +8	<input type="checkbox"/> +9	<input type="checkbox"/> +10									

If they had a Knee Replacement:

## Knee injury and Osteoarthritis Outcome Score for Joint Replacement (KOOS, JR.)

### Stiffness

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 of which you move your knee joint.

1. How severe is your knee stiffness after first wakening in the morning?

None  Mild  Moderate  Severe  Extreme

### Pain

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

2. Twisting/pivoting on your knee

None  Mild  Moderate  Severe  Extreme

3. Straightening knee fully

None  Mild  Moderate  Severe  Extreme

4. Going up or down stairs

None  Mild  Moderate  Severe  Extreme

5. Standing upright

None  Mild  Moderate  Severe  Extreme

### Function, daily living

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.

6. Rising from sitting

None  Mild  Moderate  Severe  Extreme

7. Bending to floor/pick up an object

None  Mild  Moderate  Severe  Extreme

If they had a hip replacement:

## Hip dysfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS, JR.)

**Pain**

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

1. Going up or down stairs

None  Mild  Moderate  Severe  Extreme

2. Walking on an uneven surface

None  Mild  Moderate  Severe  Extreme

**Function, daily living**

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 hip.

3. Rising from sitting

None  Mild  Moderate  Severe  Extreme

4. Bending to floor/pick up an object

None  Mild  Moderate  Severe  Extreme

5. Lying in bed (turning over, maintaining hip position)

None  Mild  Moderate  Severe  Extreme

6. Sitting

None  Mild  Moderate  Severe  Extreme