PATIENT HIP ASSESSMENT QUESTIONNAIRE

Patient Name ___________________________________________ Date_____________________
Physician: ______________________________________________

1. Have you had pain recently (within last 3 months) on the affected hip?
   - **Right Side**
     - **YES** If yes, please indicate location: □ Buttock □ Groin □ Thigh □ Lower Back □ Knee
     - **NO** Please rate the severity of the pain:
       0 1 2 3 4 5 6 7 8 9 10
     - Please indicate frequency of the pain:
       0 1 2 3 4 5 6 7 8 9 10
     - □ None □ Mild □ Moderate □ Severe □ Monthly □ Weekly □ Daily
   - **Left Side**
     - **YES** If yes, please indicate location: □ Buttock □ Groin □ Thigh □ Lower Back □ Knee
     - **NO** Please rate the severity of the pain:
       0 1 2 3 4 5 6 7 8 9 10
     - Please indicate frequency of the pain:
       0 1 2 3 4 5 6 7 8 9 10
     - □ None □ Mild □ Moderate □ Severe □ Monthly □ Weekly □ Daily

1a. Do you need to take medication for your hip pain? □Yes □No
   - **If yes**, what medications do you use? How many times per day?
     - Codeine
     - Percocet
     - Advil
     - 0 1 2 3 4 5 6 7 8 9 10
     - Demerol
     - Aleve
     - Aspirin
     - How often do you need to take medication?
     - Dilaudid
     - Tylenol #3
     - Vicodin
     - Tramadol
     - Morphine
     - Other
     - □ Monthly □ Weekly □ Daily

2. How far can you walk? 0 1 2 3 4 5 6 7 8 9 10
   - □ House Bound □ Blocks □ No Limit

3. How much assistance do you require?
   - □ Can’t Walk □ Walker □ Crutches □ Crutch □ Cane □ None

4. Do you limp because of your **affected** hip? □ Yes □ No

5. How much difficulty do you have going up or down stairs because of you **affected** hip?
   - 0 1 2 3 4 5 6 7 8 9 10
   - □ Unable □ Someone’s assistance □ Crutch or cane □ Bannister □ None
6. How much difficulty do you have putting your shoes and socks on because of your **right** hip?

   0  1  2  3  4  5  6  7  8  9  10
   NONE  MODERATE  UNABLE

7. How much difficulty do you have putting your shoes and socks on because of your **left** hip?

   0  1  2  3  4  5  6  7  8  9  10
   NONE  MODERATE  UNABLE

8. How much help do you need with your personal care activities (ie. bathing, dressing, eating, toilet) because of your **affected** hip?

   □ Independent  □ Somewhat  □ Partial  □ Dependent

9. How difficult is it doing your household activities because of your affected hip?

   □ Not at all  □ Slightly  □ Moderately  □ Greatly

10. Are you able to use public transportation?  □ Yes  □ No

11. Please indicate if you are active in any of the following activities and how often you participate in them:

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>NEVER</th>
<th>OCCASIONALLY</th>
<th>DAILY</th>
<th>WEEKLY</th>
<th>MONTHLY</th>
<th>YEARLY</th>
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</thead>
<tbody>
<tr>
<td>Walking</td>
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<td>Tennis(doubles)</td>
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