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: Please indicate frequency of the pain:

0 1 2 3 4 5 6 7 8 9 10 **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: Please indicate frequency of the pain:

0 1 2 3 4 5 6 7 8 9 10 **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	**0 1 2 3 4 5 6 7 8 9 10**
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:

ACTIVITY	NEVER	OCCASIONALLY	DAILY	WEEKLY	MONTHLY	YEARLY
Walking						
Running						
Swimming						
Cycling						
Gym						
Tennis(singles)						
Tennis(doubles)						
Golf						