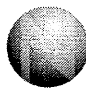



# NEW PATIENT HIP SURVEY

Last Name________________________ First Name_______________________ MRN:___________________

**BACKGROUND INFORMATION**

Height_________________ Weight_______________

**CURRENT PROBLEM**

Is your problem in the: ______ right hip ______ left hip ______ both hips

Who referred you to see us? ________________________________________

When did the problem start? ______________________ Did it start: ______ Gradually ______ Suddenly

Was this a result of an injury? ______ Yes ______ No If yes, what occurred? ____________________________

What do you do for work? ____________________________________________________________________

What do you do for fun? _____________________________________________________________________

Has your hip prevented you from doing what you want to do? ______ Yes _______ No

**SURVEY INSTRUCTIONS:** Please mark one choice for each topic.

**Pain**
____None/Able to ignore it
____Slight, occasional, no compromise in activity
____Mild, no effect on ordinary activity, pain after usual activity, uses aspirin/ibuprofen/Tylenol
____Moderate, tolerable, makes concessions, occasional narcotic/codeine
____Marked pain, serious limitation of activities
____Totally disabled, crippled, bedridden

**PAIN QUESTIONS**

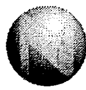
**Location of Pain**

____ Deep/Groin ____ Buttock ____ Front/Thigh ____ Outer Side ____ All Over
____ Back ____ Lower Abdomen ____Other (List):_____________________________

How often do you experience pain? ____ Never ____ Monthly ____ Weekly ____ Daily ____ Always

What factors aggravate your pain? Please rate the following with the most aggravating being a 1 and the least aggravating an 8.
____ Sitting (i.e. Prolonged car ride, sitting at desk) ____ Standing
____ Putting on socks and shoes or bending forward ____ Walking
____ Start-up pain ____ Stairs
____Sports (list here): _______________________________________________________________
____ Other: ______________________________________________________________________

Have you ever had surgery on your hip, back, or pelvis before? ____ Yes ____ No
Type of surgery and date: ____________________________________________________________




# NEW PATIENT HIP SURVEY

**TREATMENTS**

Have you tried oral medications for this problem, and did they improve your pain?

____ NSAIDS (Please list: ________________________) Improvement in pain: ____ Yes ____ No
____ Tylenol Improvement in pain: ____ Yes ____ No
____ Steroids Improvement in pain: ____ Yes ____ No
____ Narcotics Improvement in pain: ____ Yes ____ No
____ Other (Please list: ________________________) Improvement in pain: ____ Yes ____ No

Have you tried other modalities and did it improve your pain?

____ Physical therapy Improvement in pain: ____ Yes ____ No
____ Other treatments (Please list: ________________________) Improvement in pain: ____ Yes ____ No

Have you had an injection? ____Yes ____No

____ Joint/intra-articular (using ultrasound or radiographic guidance)
____ Bursa (lying on the side and in the outside of the hip without guidance)
____ Psoas
____ Other: ________________________

What percentage of your pain was relived? ________________ For how long? ________________________

How did you feel in the 6 hours immediately following the injection? Did you get any initial relief that didn't last?

______________________________________________________________________________

NORTHLAND ORTHOPEDICS & SPORTS MEDICINE

# NEW PATIENT HIP SURVEY

**Quality of Life Survey:** Please answer all questions using a 0-100 scale, with 0 being the ***worst hip related quality of life*** and 100 being ***normal hip related quality of life***. Please **CIRCLE** the number that represents your condition best.

1. Overall, how much pain do you have in your hip/groin?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)

2. How difficult is it for you to get up and down off the floor/ground?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)

3. How difficult is it for you to walk long distances?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)

4. How much trouble do you have with grinding, catching or clicking in your hip?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)

5. How much trouble do you have pushing, pulling, lifting, or carrying heavy objects at work?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)

6. How concerned are you about cutting/changing directions during your sport or recreational activities?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)

7. How much pain do you experience in your hip after activity?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)

8. How concerned are you about picking up or carrying children because of your hip?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)

9. How much trouble do you have with sexual activity because of your hip?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)

10. How much of the time are you aware of the disability in your hip?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)

11. How concerned are you about your ability to maintain your desired fitness level?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)

12. How much of a distraction is your hip problem?
0(worst) ____10____20____30____40____50____60____70____80____90_____100(normal)