

HIP HISTORY

NAME: _____ DATE: _____
Last Name First Name Middle Initial

Please answer each of the following questions by checking/ writing as many responses as necessary. If the answer you need is not available, please feel free to write it in.

How old are you? _____ What is your occupation? _____
Where do you live(City, State)? _____
Who referred you to our office? _____ Previous patient? Yes No
With which hip are you experiencing difficulty? Right Left Both
Right worse then left
Left worse then right

How long have you been experiencing difficulty with your hip? _____
What do you think may have caused your hip symptoms (for example, spontaneous, over use exercise, specific injury an accident)? _____

Which of the following elbow symptoms are you experiencing? Please mark all that apply by ranking them in order of decreasing severity with one (1) as most significant symptom.

- ___ Pain ___ Numbness/ Tingling
- ___ Stiffness ___ Instability/ slipping sensation
- ___ Weakness ___ Dislocation
- ___ Catching ___ Popping
- ___ Grinding ___ Swelling

Where do you experience the majority of your hip pain?
___ At the front of the hip ___ On the outer side of the hip
___ At the back of the hip ___ Generalized pain
___ On the inner side/groin

Does your hip pain radiate (move)?
___ NO ___ Yes Which direction? _____

Please check all that apply to your hip discomfort:
___ Aching ___ Constant
___ Sharp ___ Intermittent
___ Burning ___ Present only with certain activities

Please mark the severity of your hip discomfort on a scale of 1 to 10 on the line below
(1= minimal, 10= extremely severe) |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
1 5 10
Minimal Moderate Severe

Do you have discomfort with any of the following motions or activities?
___ Going up stairs ___ Going down stairs ___ Sitting for a prolonged period of time
___ Squatting or bending down

Does your hip problem interfere with any of the following:

Daily activities

School activities

Work activities

Recreation or sports activities

Please explain: _____

Do you experience hip pain at night which interferes with your sleep? Yes No

Have you previously had your hip evaluated by:

Primary care physician

Another orthopedic surgeon

Emergency room visit

Have you had any of the following imaging studies for your hip?

X-ray

CT scan

MRI

Bone scan

Arthogram

Other _____

Please check any treatments that you have tried for your hip condition?

Has treatment helped?

Rest

Yes No

Ice application

Yes No

Anti-inflammatory medications(which ones) _____

Yes No

Pain Medication (which ones) _____

Yes No

Cortisone injection(last one) _____

Yes No

Physical therapy

Yes No

Crutches

Yes No

Other _____

Yes No

How is your hip progressing?

Getting better

Staying the same

Getting worse

Does anyone in your family have a history of hip disorders? Yes No

Have you ever had any other significant hip injuries in the past? Yes No

If yes, please explain: _____

If yes, did you fully recover? Yes No

Have you ever had hip surgery? Yes No

If yes, please explain (date, doctor, procedure if known): _____

Please list any other information you feel would assist your doctor with your treatment.

