

# 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? \_\_\_\_\_ Is the referring person a previous patient? \_\_\_ Yes \_\_\_ No

With which hip are you experiencing difficulty? \_\_\_ Right \_\_\_ Left \_\_\_ Both  
\_\_\_ Right worse than left  
\_\_\_ Left worse than right

How long have you been experiencing difficulty with your hip? \_\_\_\_\_

On what date did your symptoms begin (if known)? \_\_\_\_\_

What do you think may have caused your hip symptoms (for example, spontaneous, overuse, exercise, specific injury an accident)? \_\_\_\_\_

Which of the following hip 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  
\_\_\_ Stiffness  
\_\_\_ Weakness  
\_\_\_ Instability/ slipping sensation  
\_\_\_ Popping/ Grinding/ Catching  
\_\_\_ Swelling  
\_\_\_ Other \_\_\_\_\_

Where do you experience the majority of your hip pain?

\_\_\_ At the front of the hip  
\_\_\_ At the back of the hip  
\_\_\_ On the inner side/groin  
\_\_\_ On the outer side of the hip  
\_\_\_ Generalized pain

Does your hip pain radiate (move)? \_\_\_ NO \_\_\_ Yes Which direction? \_\_\_\_\_

Please check all that apply to your hip discomfort:

\_\_\_ Aching  
\_\_\_ Sharp  
\_\_\_ Burning  
\_\_\_ Constant  
\_\_\_ Intermittent  
\_\_\_ 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



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DATE: \_\_\_\_\_

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? Please include dates, if known.

\_\_\_\_ X-ray      \_\_\_\_ Bone Scan  
\_\_\_\_ MRI      \_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_ CT Scan

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

\_\_\_\_ Rest  
\_\_\_\_ Ice application  
\_\_\_\_ Anti-inflammatory medications (Which medication) \_\_\_\_\_  
\_\_\_\_ Pain Medication (Which medication) \_\_\_\_\_  
\_\_\_\_ Cortisone injection (Date) \_\_\_\_\_  
\_\_\_\_ Physical therapy  
\_\_\_\_ Sling/ Brace  
\_\_\_\_ Other \_\_\_\_\_

Has treatment helped?

\_\_\_\_ Yes      \_\_\_\_ No  
\_\_\_\_ Yes      \_\_\_\_ No  
\_\_\_\_ Yes      \_\_\_\_ No  
\_\_\_\_ Yes      \_\_\_\_ No  
\_\_\_\_ Yes      \_\_\_\_ No  
\_\_\_\_ Yes      \_\_\_\_ No  
\_\_\_\_ 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, and procedure if known): \_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

