HIP PAIN QUESTIONNAIRE

***HIP PAIN*: (If you have pain on only one side, you can skip questions related to the other side.)**

What side is your pain on?

☐Left ☐Right ☐Bilateral. If Bilateral: ☐ Equal ☐ Left greater than Right ☐ Right greater than Left

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How long have you had hip problems?

Left hip:

Please specify how many days, weeks, months, or years:_____

Right hip:

Please specify how many days, weeks, months, or years:_____

How severe is your pain? (Circle one.) 0 is no pain and 10 is worst pain of your life.

Left hip:

SCALE OF PAIN: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Right hip:

SCALE OF PAIN: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Where do you feel your hip pain? (Mark all that apply or describe it yourself on the blank line provided)

Left hip: _____

☐Groin ☐ Side of hip ☐Front of thigh ☐ Inner thigh-medial ☐ Outer thigh-lateral
☐ Buttocks ☐ Lower back ☐ Sacroiliac join ☐ Back of the thigh

Right hip: _____

☐Groin ☐ Side of hip ☐Front of thigh ☐ Inner thigh-medial ☐ Outer thigh-lateral
☐ Buttocks ☐ Lower back ☐ Sacroiliac join ☐ Back of the thigh

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What does the pain feel like? (Mark all that apply or describe it yourself on the blank line provided)

Left hip: _____

☐Dull ☐Achy ☐Sharp ☐A baseline dull and achiness with episodes of sharp pain
☐Throbbing ☐Burning ☐ Clicking ☐Catching

Right hip: _____

☐Dull ☐Achy ☐Sharp ☐A baseline dull and achiness with episodes of sharp pain
☐Throbbing ☐Burning ☐ Clicking ☐Catching

Does the pain radiate? Yes / No. If yes, where does it radiate to? (Mark all that apply or describe it yourself)

Left hip: _____

☐Groin to knee ☐To the ankle ☐Into foot ☐Into the toes
☐ Groin to side of hip ☐Groin to buttock ☐Down back of leg to knee ☐Down back of leg to foot

Right hip: _____

☐Groin to knee ☐To the ankle ☐Into foot ☐Into the toes
☐ Groin to side of hip ☐Groin to buttock ☐Down back of leg to knee ☐Down back of leg to foot

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Pain is aggravated by: (Mark all that apply or describe it yourself on the blank line provided)

Left hip: _____

☐Ascending stairs ☐Descending stairs ☐Arising from a chair ☐Kneeling or squatting ☐Laying on side of hip
☐ Walking ☐ Exercise ☐Getting in/out of a car ☐Putting on shoes and socks ☐Pushing on side of hip

Right hip: _____

☐Ascending stairs ☐Descending stairs ☐Arising from a chair ☐Kneeling or squatting ☐Laying on side of hip
☐ Walking ☐ Exercise ☐Getting in/out of a car ☐Putting on shoes and socks ☐Pushing on side of hip

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Pain is relieved by: (Mark all that apply or describe it yourself on the blank line provided)

Left hip: _____

☐Rest ☐Sitting ☐Standing ☐Lying down ☐Stretching

☐Pain medications ☐Topical ointments ☐Topical patches ☐Ice ☐Heat ☐Nothing

Right hip: _____

☐Rest ☐Sitting ☐Standing ☐Lying down ☐Stretching

☐Pain medications ☐Topical ointments ☐Topical patches ☐Ice ☐Heat ☐Nothing

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Associated symptoms?

Left hip: _____

☐None ☐ Clicking ☐ Popping ☐Locking ☐Catching

Right hip: _____

☐None ☐ Clicking ☐ Popping ☐Locking ☐Catching

Do you have a history of back pain? Yes / No. Do you have sciatica? Yes / No

If yes, please explain:_____

How does your hip pain affect your ability to walk?

Left hip: _____

☐No difficulty ☐Slight ☐Mild ☐Moderate ☐Marked/serious limitations

☐Only walks around the house ☐Totally disabled, wheelchair bound

Right hip: _____

☐No difficulty ☐Slight ☐Mild ☐Moderate ☐Marked/serious limitations

☐Only walks around the house ☐Totally disabled, wheelchair bound

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How far can you walk without stopping because of your hip pain?

Left hip: _____

☐Unlimited ☐ > 6 blocks (30 mins) ☐2-3 blocks (10-15 minutes) ☐< 1 block ☐Indoors only ☐Bed to chair

Right hip: _____

☐Unlimited ☐ > 6 blocks (30 mins) ☐2-3 blocks (10-15 minutes) ☐< 1 block ☐Indoors only ☐Bed to chair

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Do you need support when walking?

☐ None ☐ Cane for long walks ☐ Cane full time ☐ One crutch

☐ Two canes ☐ Two crutches ☐ Walker ☐Unable to walk / wheelchair

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What have you tried to improve your hip pain?

☐Weight loss ☐NSAIDs ☐Tramadol ☐ Tylenol ☐Physical therapy

☐Cane/Walker ☐Glucosamine ☐Cortisone injections ☐Other: _____

If you've had an injection in the involved joint, how many have you had?

Left hip:

☐None ☐One ☐ Two ☐ Three ☐ Other: _____. When was the last one injection? _____

Right hip:

☐None ☐One ☐ Two ☐ Three ☐ Other: _____. When was the last one injection? _____

Do you feel your legs are equal in length?

☐Yes, they feel equal. ☐ Right feels longer by about _____? ☐ Left feels longer by about _____?

Have you ever had a DVT (deep vein thrombosis)? Yes / No

Have you ever had a PE (pulmonary embolism? Yes / No

Do you have any history of bleeding or clotting disorders? Yes / No

Has anyone in your immediate family had a DVT or PE? Yes / No

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Current living arrangements:

- ☐ I live alone in a house or apartment
- ☐ I live in a house or apartment with my spouse/relatives or other(s)
- ☐ I live in a nursing home or residential health care facility
- ☐ Other: _____
- ☐ Do you have stairs in your home/apartment? Yes / No. If yes, how many? _____

PAST SURGERIES: ☐ **NONE** – OR LIST: (If yes, please specify date of surgery):

Previous Surgery on _____?	(mm/yyyy)	Type of Surgery and Name of Surgeon
Left knee: ☐YES ☐NO	_____	_____
Right knee: ☐YES ☐NO	_____	_____
Left hip: ☐YES ☐NO	_____	_____
Right hip: ☐YES ☐NO	_____	_____

Previous infection _____?

Left knee: ☐YES ☐NO **Left hip:** ☐YES ☐NO **Other:** _____

Right knee: ☐YES ☐NO **Right hip:** ☐YES ☐NO

Other types of surgery?	Date of Surgery (mm/yyyy)
_____	_____
_____	_____
_____	_____