Patient Name_____________________________

Date of Birth:________/________/___________

GSMG Orthopaedic Surgery

# Hip History

Date of Visit: ____ /____ / _______

Which hip are we seeing you for, today? (Circle ONLY ONE of the following): *Right/ Left/ Both*

What bothers you the most about your hip(s)? Circle ONLY ONE of the following:
*Pain, Catching, Locking, Instability (Giving Out), Grinding, Popping*
*Other:*_______________________________________________

What else bothers you about your hip(s)? Circle ALL of the following that apply to your hip(s):
*Pain, Catching, Locking, Instability (Giving Out), Grinding, Popping*
*Other:*_______________________________________________

When did the hip symptoms begin? ______________________________

Are symptoms worsening/progressing over time? Yes/No

Was there ever an injury to the hip? Yes/No If "Yes", when was the injury? ______________
If "Yes," how was it injured? ______________

Did you ever have troubles with either hip during childhood? Yes/No ______________

Have you ever had surgery performed on your RIGHT hip? Yes/No

If "Yes", what type of surgery(s) and when? (1)__________ (3)__________
(2)__________ (4)__________

Have you ever had surgery performed on your LEFT hip? Yes/No

If "Yes", what type of surgery(s) and when? (1)__________ (3)__________
(2)__________ (4)__________

Have you ever had an infection in either hip? Yes/No ______________

Have you ever had a blood clot (DVT) in either leg? Yes/No ______________

Have you ever had a blood clot (pulmonary embolism) go to your lungs? Yes/No ______________

Does your RIGHT KNEE bother you? Yes/No ______________

Does your LEFT KNEE bother you? Yes/No ______________

Does your LOW BACK bother you? Yes/No ______________

Do you ever have numbness or tingling in either leg or foot? Yes/No ______________

Where is your HIP pain located?*(please circle all that apply):*

| Right Hip: | Left Hip: |
|---|---|
| None | None |
| Groin | Groin |
| On the side | On the side |
| Buttock | Buttock |
| Radiates to knee | Radiates to knee |

Is your hip pain worsened by activity that involves bearing weight (walking / standing)? Yes/No

Is your hip pain helped by rest (avoiding activity)? Yes/No

Do you have pain in your hip at night? Yes/No

If "Yes", does your night pain interfere with sleep? Yes/No

What activities aggravate your hip? ______________________________

______________________________

______________________________

______________________________

What activities have you had to limit or avoid because of your hip? ______________________________

______________________________

______________________________

______________________________

Do you feel that your quality of life is suffering because of your hip ? Yes/No ____________

If "Yes," how much is your quality of life suffering?

*(Please circle one of the following):* *Mildly / Moderately / Severely*

Is your quality of life suffering enough for you to consider hip surgery? Yes/No ____________

# Prior Treatment:

Have you used medication(s) for your hip? Yes/No

| Medication Name: | Did it Help? | Are you still taking it? |
|---|---|---|
| (1) ______________________: | Yes/No ______________________: | Yes/No |
| (2) ______________________: | Yes/No ______________________: | Yes/No |
| (3) ______________________: | Yes/No ______________________: | Yes/No |
| (4) ______________________: | Yes/No ______________________: | Yes/No |
| (5) ______________________: | Yes/No ______________________: | Yes/No |

Has your hip ever been injected with cortisone? Yes/No

How many times? ________

Was X-ray guidance used? Yes/No

Did cortisone injection(s) help? Yes/No ______________________________

Have you had physical therapy for your hip? Yes/No Did this help? Yes/No

Have you had chiropractic treatment for your hip? Yes/No Did this help? Yes/No

Do you use a cane/walking stick because of your hip? Never/Sometimes/Always/ In the past

Do you use a walker because of your hip? Never / Sometimes / Always/ In the past

Do you use crutches because of your hip? Never / Sometimes / Always/ In the past

What other treatment(s) have you tried? ______________________ Did this help? Yes/No

______________________ Did this help? Yes/No

______________________ Did this help? Yes/No

Is there any other information that you would like to share with us about your hip?

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

***Thank you very much for completing all of these forms!***