New Patient Questionnaire – HIP

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HOSPITAL FOR SPECIAL SURGERY

Name:	DOB:	Date:
Height:	Weight:	Age:

Chief Complaint

Laterality	Left	Right	Both

Please describe your symptoms: (Mark all that apply)

Throbbing pain	Radiating pain	Dull pain	Sharp pain
Catching/Locking	Swelling	Stiffness	Instability
Other:			

Where is the pain located in your hip? (Mark all that apply)

Groin	Thigh	Outside	Buttocks	Other:

Current Pain Level (no pain 0 – 10 highest)

While Walking

0	1	2	3	4	5	6	7	8	9	10

While negotiating stairs

0	1	2	3	4	5	6	7	8	9	10

At rest (sitting, lying down, sleeping)

0	1	2	3	4	5	6	7	8	9	10

When did this condition start? _____

How did start? _____

What makes the pain better? _____

What makes the pain worse? _____

Have you EVER tried any prior conservative treatment?	Yes	No	How long?	Did it help?
Acupuncture or holistic remedies				.
Arthroscopic surgery				.
Brace / Cane / Crutches / Walker				.
Cortisone injections				.
Dietary supplements				.
Viscosupplementation (Gel injections)				.
NSAIDS *(eg: Ibuprofen, Aspirin, Naproxen, Celebrex, Voltaren)*				.
Narcotics				.
Physical therapy				.
Weight loss				.
Exercise program				.
Activity modification / Lifestyle change				.

Functional Assessment

Do you have a limp?

No	Slight	Moderate	Severe

What type of support do you use for walking?

None	Cane (long walks)	Cane (full time)	Crutch(es)	Walker

What distance are you able to walk?

Unlimited	6 blocks	2-3 blocks	< 1 block	Bed to chair

How do you climb stairs?

Normally	With banister	With assistance of a person	Unable

To what extent are you able to put on shoes and socks?

Easy	Difficult	Unable

Describe the extent to which you are able to sit:

Any chair, 1 hour	High chair, 30 minutes	Unable

Are you able to use public transportation?

Yes	No

Do you find this situation to be:

Acceptable	Unacceptable

HOOS, JR. Hip Survey

Instructions: This survey asks for you view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.

Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Which Hip:

Left	Right	Both

Pain: What amount of hip pain have you experienced the last week during the following activities?

1. Going up or down stairs:

None	Mild	Moderate	Severe	Extreme

2. Walking on an uneven surface:

None	Mild	Moderate	Severe	Extreme

Function, daily living: The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experience in the last week due to your hip.

3. Rising from sitting:

None	Mild	Moderate	Severe	Extreme

4. Bending to floor/pick up an object:

None	Mild	Moderate	Severe	Extreme

5. Lying in bed (turning over, maintaining hip position):

None	Mild	Moderate	Severe	Extreme

6. Sitting:

None	Mild	Moderate	Severe	Extreme

Medications: *Please list the medications that you CURRENTLY take*

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Allergies: *Please include any known allergies*

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Are you allergic to iodine? Yes No

Are you allergic to latex? Yes No

Are you to metal, jewelry, or nickel? Yes No

Medical History

Please select any past or current medical conditions below:			
Anxiety	Depression	Kidney disorder	Pulmonary embolus
Arrhythmia (Irregular heartbeat)	Diabetes	Low acting thyroid	Reflux
Asthma	Heart attack	Open wounds/Ulcers	Rheumatoid arthritis
Bleeding problems	Heart failure (CHF)	Osteoarthritis	Seizures
Blood clots (DVT-PE)	High blood pressure	Osteoporosis	Stomach ulcers
Cancer	High cholesterol	Peripheral vascular disease	Stroke
Coronary artery disease	Infection	Pneumonia	Other:

Surgical and Hospitalization History

Previous operation/Hospitalization	Occurrence date (approx.)
1.	
2.	
3.	
4.	
5.	

Have you ever had a problem with anesthesia? Yes No Problem: _____

Have you ever had complications from prior surgery? Yes No Problem: _____

Family History

What medical problems run in your direct family?

Family member	Problem	Alive/Deceased
Father		
Mother		
Brother		
Sister		
Grandfather		
Grandmother		

Social History

Are you a tobacco user? Yes No

If yes, what? _____ How much? _____

Do you consume alcohol? Yes No

If yes, what kind? _____ Drinks per week? _____

Recreational drug use? Yes No

If yes, what drug? _____ How much and how often? _____

List any recreational activities / sports that you enjoy: _____

What do you do for a living? _____

With whom do you live? _____

Screening Questions (Coordination of Care)

Are you currently on any blood thinners? Yes No

Have you ever had a MRSA Infection? Yes No

Do you have any of the following medical devices? (Mark all that apply)

Pain Pump	Neurostimulator	Pacemaker and/or Defibrillator	Shunt for hydrocephalus

Do you have diabetes? Yes No

If yes, do you have an insulin pump? Yes No

Have you been taking opioids for 6 months or more (e.g. codeine, percocet, morphine, Vicodin, etc.)? Yes No

Immunizations and Falls Screening

Have you received the pneumonia vaccine? Yes No

If yes, date? _____ If not, why? _____

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? Yes No

If yes, date? _____

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? Yes No

If yes, do you have vision problems that may have contributed to your fall? Yes No

Review of Systems

Are you currently having, or have you had any of these problems in the past year? (Select all that apply):

Constitutional	Hematologic	Respiratory	Skin
Chills	Easy bruising/bleeding	Increased sputum	Sores/ulcers
Fever	Blood clots in legs	Cough	Itching
Sleep difficulty	Blood clots in lungs	Difficulty breathing	Dryness
Fatigue		Wheezing	Hives
Night sweats		Excessive snoring	Rash
Weight Change			Mole changes
None	None	None	None

ENT	Cardiovascular	Endocrine	Musculoskeletal
Double vision	Chest pain	Cold intolerance	Joint pain
Headaches	Leg swelling	Heat intolerance	Arthritis
Hearing loss	Palpitations	Excessive thirst	Muscle pain
Cataracts	Poor circulation	Excessive hunger	Joint swelling
Glaucoma	Cold hands		Muscle cramps
Dry eyes	Cold feet		Muscle weakness
Sinus problem			Joint stiffness
None	None	None	None

Gastrointestinal	Genitourinary	Neurological	Psychiatric
Abdominal pain	Bladder incontinence	Seizures	Depression
Trouble swallowing	Blood in urine	Dizziness	Anxiety
Heartburn	Urinary difficulty	Weakness	Mood swings
Nausea	Painful urination	Loss of balance	Memory problems
Vomiting	Urinary retention	Numbness	Nervousness
Constipation	Urinary urgency	Paralysis	Insomnia
None	None	None	None

Eyes	Environmental Allergies	Mouth
Dryness	Pollen	Bad breath
Discharge	Dust Mites	Bleeding gums
Double Vision	Pets/Animals	Sores – ulcers
Pain	Mold/Mildew	Dental problem
Redness	Metal	Loss of taste
None	None	None