UTAH ORTHOPAEDIC SPECIALISTS

Hip Questionnaire

Name:_____ Date:_____

1. Do you have a history of a deep vein clot or pulmonary embolism? _____
2. What happened to your hip? _____

   _____

   When did it happen? Date: _____ Which side? L or R
3. How long have you had pain? Years: _____ Months: _____ Weeks: _____
4. What activities cause pain? _____
5. Type of pain/discomfort (e.g., achy, burning, sharp) _____
6. The pain is (circle one): mild: moderate: severe:
7. How long does it last? _____ When does it occur? _____
8. Any specific activity? _____
9. What makes it worse? _____
10. What makes it better? _____
11. Associated symptoms (e.g., numbness, popping, weakness, etc.)? Describe them:

    _____
12. What treatment have you had in the past (include physical therapy)? _____
13. Are you (please circle) better, worse, or the same since your treatment began? _____
14. Do you have pain in your hip at night? Yes or No
15. Have you ever had any surgery done no your hip? Yes or No
16. Have you ever had a cortisone injection in your hip? Yes or No

    If so, how many times? _____

    When were the shots given? Date: _____

    How long did the injection last? _____
17. What athletic activities do you participate in? Please list: _____
18. Who referred you to this office? _____
19. How bad is your pain today (mark line with an **X**)?

    _____

    No pain at all Pain as bad as it can be