Hip Evaluation
William F. Sima, M.D.

Name: ______________________________ **Date:** ____________

What hip are you here for? ☐ Right
☐ Left

Your first symptoms began: ☐ Suddenly
☐ Gradually

In detail please explain how you injured yourself _____________________________
____
____

What date did your pain begin? ___________

Previous Treatment:
☐ I have not received any treatment for this condition
I was evaluated by _____________________ at:
☐ Twin Cities Hospital ☐ French Hospital
☐ Sierra Vista Hospital ☐Urgent Care ☐Other__________

Referring physician: _________________________

☐ X-rays – Where: ________
☐ MRI – Where: _________
☐ Physical Therapy - Where: ___________
☐ Cortisone Injection
☐ Surgery - With: ___________

Current Symptoms: ☐ Feeling great ☐Somewhat better ☐ Worse
☐ Much better` ☐ Same as it was

Quality of Pain:
☐ No pain
☐ Achy
☐ Burning
☐ Dull
☐ Gnawing
☐ Pressure
☐ Sharp
☐ Stiffness
☐ Throbbing
☐ Tightness
☐ Tired feeling

Pain Radiates:
☐ Into the groin
☐To the thigh
☐ Down the leg
☐Down the leg to the foot
☐To or from the back

Pain Worse With:
☐Bending
☐Driving
☐ Exercise
☐ Prolonged sitting
☐ Kneeling
☐ Pivoting
☐ Sitting
☐ Putting on socks & shoes
☐ Running
☐ Shopping
☐ Getting in/out of chair
☐ Sitting Indian style
☐ Sleeping
☐ Squatting
☐ Stairs
☐ Standing
☐ Walking
☐ Weight bearing
☐ Other: _______

Other Symptoms:
☐ Intermittent locking
☐ Cracking
☐ Popping
☐ Catching
☐ Clicking
☐ Tightness

Walking Ability:
☐ Very limited
☐ Limited to a few stairs
☐ 1-2 blocks
☐ 5-10 blocks
☐ More than 10 blocks
☐ Not limited

Name: ________________________________ **Date:** __________

Sports Limitations:
☐ Has no limitations
☐ Participates with difficulty in: ________________________
☐ Unable to participate in: ________________________

Walking Aids:
☐ Cane
☐ Crutches
☐ Walker
☐ Shopping cart
☐ Brace
☐ Shoe inserts
☐ Boots

Medications for pain:
☐ Not required
☐ Used occasionally
☐ Required daily
☐ Brace for sports
☐ Orthotics

Location of Pain:
☐ Groin
☐ Thigh
☐ Buttock
☐ Side of hip

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 experienced 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