**Name:** **D.O.B:**

**Side:** Left Right Bilateral

**Evaluation:** Pre-operative 6 weeks 6 months Years Post Op

**Please tick the box which best describes:**

**PAIN**

|  |  |
| --- | --- |
| ☐ | None or ignores it |
| ☐ | Slight, occasional, no compromise in activities |
| ☐ | Mild pain, no effect on average activities, rarely moderate pain with unusual activities, may take aspirin |
| ☐ | Moderate pain, tolerable but makes concessions to pain. Some limitation of ordinary activity or work. May require occasional pain medicine stronger than aspirin |
| ☐ | Marked pain, serious limitation of activities |
| ☐ | Totally disabled, crippled, pain in bed, bed-ridden |

**FUNCTION**

**Gait**

|  |  |  |
| --- | --- | --- |
| **1. Limp** | **2. Support** | **3. Distance Walked** |
| ☐ None  ☐ Slight  ☐ Moderate  ☐ Severe | ☐ None  ☐ Cane for long walks  ☐ Cane most of the time  ☐ One crutch  ☐ Two canes  ☐ Two crutches  ☐ Not able to walk | ☐ Unlimited  ☐ Six Blocks  ☐ Two or three blocks  ☐ Indoors only  ☐ Bed and chair |

**Please continue on next page…**

**Activities**

|  |  |
| --- | --- |
| **1. Stairs** | **2. Shoes and Socks** |
| ☐ Normally without using railing  ☐ Normally using railing  ☐ In any manner  ☐ Unable to do stairs  **3. Sitting**  ☐ Comfortably in normal chair for 1 hour  ☐ On a high chair for half an hour  ☐ Unable to sit comfortably in any chair | ☐ With ease  ☐ With difficulty  ☐ Unable  **4. Public Transport**  ☐ Can enter  ☐ Unable to enter |