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

**Side:** Left Right Bilateral

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

**How would you describe the pain**

**you usually have in your hip?**

☐ None

☐ Very Mild

☐ Mild

☐ Moderate

☐ Severe

**Have you been troubled by pain**

**from your hip at night?**

☐ No nights

☐ Only 1 or 2 nights

☐ Some nights

☐ Most nights

☐ Every night

**Have you had any sudden, severe**

**pain- “shooting, stabbing or spasms”?**

☐ No days

☐ Only 1 or 2 days

☐ Some days

☐ Most days

☐ Every day

**Have you been limping when**

**walking because of your hip?**

☐ Rarely/never

☐ Sometimes or just at first

☐ Often, not just at first

☐ Most of the time

☐ All of the time

**How long can you walk for before**

**the pain in your hip becomes severe**

**(with or without a walking aid)?**

☐ No pain for 30 minutes or more

☐ 16-30 minutes

☐ 5-15 minutes

☐ Around the house only

☐ Not at all

**Have you been able to climb a**

**flight of stairs?**

☐ Yes, easily

☐ With a little difficulty

☐ With moderate difficulty

☐ With extreme difficulty

☐ No, impossible

**Have you been able to put on socks**

**stockings or tights?**

☐ Yes, easily

☐ With a little difficulty

☐ With moderate difficulty

☐ With extreme difficulty

☐ No, impossible

**After sitting to a meal, how painful is it to stand up because of your hip?**

☐ Not painful at all

☐ Slightly painful

☐ Moderately painful

☐ Very painful

☐ Unbearable

**Have you had any trouble getting in and out of a car or public transportation because of your hip?**

☐ No trouble at all

☐ Very little trouble

☐ Moderate trouble

☐ Extreme difficulty

☐ Impossible to do

**Have you had any trouble with washing and**

**drying yourself, all over, because of your hip?**

☐ No trouble at all

☐ Very little trouble

☐ Moderate trouble

☐ Extreme difficulty

☐ Impossible to do

**Could you do the household shopping on your own?**

☐ Yes, easily

☐ With a little difficulty

☐ With moderate difficulty

☐ With extreme difficulty

☐ No, impossible

**How much has pain from your hip interfered**

**with your usual work, including housework?**

☐ Not at all

☐ A little bit

☐ Moderately

☐ Greatly

☐ Totally