**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 |