HIP QUESTIONNAIRE

Patient Name: _____ DOB: _____

1.) Which hip(s) did you hurt? Do you have back/leg pain? Do you have numbness/tingling? Describe your distribution of pain (i.e., groin, side of hip, buttock, thigh, knee, calf, foot). Be specific.

_____
_____

2.) Is this work comp? Yes No Litigation pending? Yes No
What is your job description?

_____

___ hrs/day, ___ days/week What is your current job status? _____

3.) Where were you, and what were you doing, when you injured your hip?

_____

4.) When did you hurt your hip? _____

5.) When is the pain the worst? Be specific.

_____

6.) Rate your pain (0 for no pain, 10 for most pain): ___\10

7.) Describe your pain (circle all that apply):

sharp dull stabbing burning throbbing aching

8.) Do you have history of prior hip surgery? Yes no

9.) Do you have any of the following symptoms (circle all that apply)?

Locking catching popping clicking giving way
swelling numbness tingling weakness limping

10.) Do you have pain at night or at rest?

11.) Since the problem started, is the pain:

Getting better getting worse unchanged

12.) What makes the pain worse (circle all that apply)?

Standing walking lying in bed coughing lifting bending
sitting sneezing changing from sitting to standing

Other: _____

13.) What improves your pain (circle all that apply)?

Rest ice heat standing sitting Ibuprofen/Aleve Tylenol

Other: _____

14.) Do you smoke? Yes No If yes, ___ packs/day x ___ years

15.) Do you drink regularly? Yes No If yes, ___ drinks/day x ___ years

16.) Do you have prior history of hip pain? Yes no

If yes, did your prior treatment rendered by a physician include the following:

NSAIDs Cane/Crutches PT/OT Home exercises

Injection Narcotic meds Acupuncture Chiropractor

Other:_____

17.) Did the treatment help? Yes No

18.) Have you had any x-rays/MRI/CT or other prior imaging studies? Yes No

If yes, what study and where was it performed? _____

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been acurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to third party payors and/or health practicioners. I authorize and request my insurance company to pay directly to the physician insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____	_____	_____
Patient's Signature	MD/PA Signature	Date

Recall Review Signatures: Date:

1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____