

PATIENT NEW HIP PROBLEM

(Please circle or fill in completely)

Date: _____

Name:		SS #:		
Age:	Date of birth:	Height:	Weight:	
Sex:	Male	Female		
Is this a 2nd opinion:	Yes	No		
Pain in which leg:	Right	Left	Both	
Why are you here? Describe Hip Problem:				
Duration of symptoms: _____ days _____ weeks _____ months _____ years				
Was problem caused by an Injury?	Yes	No		
If yes, describe injury & date:				
<u>Pain is located in the:</u>				
Groin	Yes	No		
Buttock	Yes	No		
Side of Hip	Yes	No		
Thigh	Yes	No		
Knee	Yes	No		
Lower leg	Yes	No		
Foot	Yes	No		
I have Pain at night	Yes	No		
Pain is getting	Worse	Better		
Pain frequency	Constant	Occasional		
Pain level	Intolerable	Tolerable		
Pain intensity	Severe	Moderate		Mild
<u>Treatments to Date for Hip Problem:</u>				
1. Medications taken for this problem:	Aspirin	Ibuprofen	Tylenol	
Other Pain Medications:				
Did medication help?	Yes	No		
2. Steroid (Cortisone) injections?	Yes	No		
How many injections? (When, how long, did it help?)				
4. Physical therapy	Yes	No		
(When, how long, did it help?)				
5. List all Hip Surgeries (Dates & surgeon's names)				