

Name: _____

Date of Birth: _____ Today's Date: _____

Left Hip Date of Surgery: Month _____ Year _____

Right Hip Date of Surgery: Month _____ Year _____

Do you have hip pain?

	Right	Left
No pain or ignore pain	<input type="checkbox"/>	<input type="checkbox"/>
Slight, occasional, no effect on ordinary activity	<input type="checkbox"/>	<input type="checkbox"/>
Mild, pain after unusual activity, use pain reliever	<input type="checkbox"/>	<input type="checkbox"/>
Moderate, tolerable, occasionally use prescribed pain reliever	<input type="checkbox"/>	<input type="checkbox"/>
Serious limitations	<input type="checkbox"/>	<input type="checkbox"/>
Disabled by pain	<input type="checkbox"/>	<input type="checkbox"/>

How are you able to put on socks and tie shoes?

	Right	Left
With ease	<input type="checkbox"/>	<input type="checkbox"/>
With difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Unable	<input type="checkbox"/>	<input type="checkbox"/>

How are you able to go up and down stairs?

	Right	Left
Normally go up and down stairs	<input type="checkbox"/>	<input type="checkbox"/>
Normally with banister	<input type="checkbox"/>	<input type="checkbox"/>
Any method	<input type="checkbox"/>	<input type="checkbox"/>
Not able to go up and down stairs	<input type="checkbox"/>	<input type="checkbox"/>

How long could you sit in a chair comfortably?

	Right	Left
Any chair, 1 hour	<input type="checkbox"/>	<input type="checkbox"/>
High chair, ½ hour	<input type="checkbox"/>	<input type="checkbox"/>
Unable to sit ½ hour in any chair	<input type="checkbox"/>	<input type="checkbox"/>

What is the distance you are able to walk?

	Right	Left
Unlimited	<input type="checkbox"/>	<input type="checkbox"/>
6 blocks	<input type="checkbox"/>	<input type="checkbox"/>
2 to 3 blocks	<input type="checkbox"/>	<input type="checkbox"/>
Indoors only	<input type="checkbox"/>	<input type="checkbox"/>
Bed and chair	<input type="checkbox"/>	<input type="checkbox"/>
Unable	<input type="checkbox"/>	<input type="checkbox"/>

Are you able to step onto a bus or van?
 not step onto a bus or van?

Please describe your usual daily activity *choose one*

- Heavy Lifting (>20lbs) or Vigorous Sports
- Moderate Physical Activity—some heavy lifting and sports
- Light Physical Activity—heavy house-cleaning, yard work, light sports (e.g., walking 1½ miles)
- Active and working on a regular basis (e.g. desk job, light housekeeping)
- Mild Activity—some walking, light shopping
- Wheelchair
- Bedridden

If you are limited in your activity, what limits you?

please check all that apply

- Your joint replacement
- Arthritis in another joint
- Your back/spine
- Weakness/Tiredness
- Breathing/Heart
- Other: _____

Are you satisfied with your joint replacement? Yes No

Comments:

FOR OFFICE USE ONLY

Is there a hip limp?

	Right	Left
None	<input type="checkbox"/>	<input type="checkbox"/>
Slight	<input type="checkbox"/>	<input type="checkbox"/>
Moderate	<input type="checkbox"/>	<input type="checkbox"/>
Severe	<input type="checkbox"/>	<input type="checkbox"/>
Unable to walk	<input type="checkbox"/>	<input type="checkbox"/>

Trendelenburg

	Right	Left
Positive	<input type="checkbox"/>	<input type="checkbox"/>
Level	<input type="checkbox"/>	<input type="checkbox"/>
Negative	<input type="checkbox"/>	<input type="checkbox"/>

	Right	Left
Compensation	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Straight Leg Raise

	Right	Left
Painful	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Hip Abductor Strength

Please circle one

Right	1	2	3	4	5
Left	1	2	3	4	5

Classification

Please check one below

- Unilateral Arthroplasty with opposite normal hip or Bilateral Arthroplasty with satisfactory function of opposite hip
- Unilateral—other hip impaired
- Multiple Arthritis or medical infirmity

Leg Length Discrepancy (in inches)

<input type="checkbox"/> Legs Equal	
<input type="checkbox"/> Right Short	True: _____ in
<input type="checkbox"/> Left Short	Apparent: _____ in
<input type="checkbox"/> Lift Used	<input type="checkbox"/> Y <input type="checkbox"/> N Size: _____

Deformity

	Right	Left
Is there a deformity?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<i>If yes, please indicate if any of the four conditions are present</i>		
Fixed adduction >10°	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Fixed internal rotation extension >10°	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Leg length discrepancy >5"	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Primary flexion contracture >30°	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Radiographic Evaluation: Acetabulum

	Right	Left
Progressive Radiolucency	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Component Migration	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Lysis	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Polywear >2mm	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Radiographic Evaluation: Femur

	Right	Left
Progressive Radiolucency	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Component Migration	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Lysis	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Range of Motion

	Right (in degrees)	Left (in degrees)
Flexion Contracture	°	°
Max Flexion	°	°
Abduction to	°	°
Adduction to	°	°
External rotation extension to	°	°
Internal rotation extension to	°	°