ORTHOPEDIC PARTNERS

Name: _____ Date: _____

Hip dysfunction and Osteoarthritis Outcome Score

INSTRUCTIONS:

This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.

Answer every question by checking the appropriate circle, only one box for each question. If you are uncertain about how to answer a question, please give the best answer you can.

Section A: Symptoms

INSTRUCTIONS: these questions should be answered thinking about your hip symptoms and difficulties during the last week.

Do you feel grinding, hear clicking, or any other type of noise from your hip?	**Never** ○	**Rarely** ○	**Sometimes** ○	**Often** ○	**Always** ○
Difficulties spreading legs wide apart	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○
Difficulties to stride out when walking	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○

INSTRUCTIONS: these questions concern the amount of joint stiffness you have experienced during the last week in your hip. Stiffness is a sensation of restriction or slowness in the ease with which you move your hip joint.

How severe is your hip joint stiffness upon awakening in the morning?	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○
How severe is your hip joint stiffness after sitting, lying, or resting later in the day?	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○

Section B: Pain

INSTRUCTIONS: these questions concern the amount of hip pain you have experienced in the last week during the following activities.

How often is your hip painful?	**Never** ○	**Monthly** ○	**Weekly** ○	**Daily** ○	**Always** ○
Straightening your hip fully	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○
Bending your hip fully	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○
Walking on a flat surface	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○
Going up or down stairs	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○
At night while in bed	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○
Sitting or lying down	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○
Standing upright	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○
Walking on a hard surface (asphalt, concrete, etc.)	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○
Walking on an uneven surface	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○

Section C: Physical Function

INSTRUCTIONS: the following questions concern your physical function. By this we mean your ability to move around and look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the last week due to your hip.

	Never	Mild	Moderate	Severe	Extreme
Descending stairs	○	○	○	○	○
Ascending stairs	○	○	○	○	○
Rising from sitting	○	○	○	○	○
Standing	○	○	○	○	○
Bending to the floor	○	○	○	○	○
Walking on a flat surface	○	○	○	○	○
Getting in/out of the car	○	○	○	○	○
Putting on socks/stockings	○	○	○	○	○
Going shopping	○	○	○	○	○
Rising from bed	○	○	○	○	○
Taking off socks/stockings	○	○	○	○	○
Lying in bed	○	○	○	○	○
Getting in/out of the bath	○	○	○	○	○
Sitting	○	○	○	○	○
Getting on/off the toilet	○	○	○	○	○
Heavy domestic duties	○	○	○	○	○
Light domestic duties	○	○	○	○	○

Section D: Function, Sports & Recreational activities

INSTRUCTIONS: the following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the last week due to your hip.

	Never	Mild	Moderate	Severe	Extreme
Squatting	○	○	○	○	○
Running	○	○	○	○	○
Twisting/pivoting on loaded leg	○	○	○	○	○
Walking on uneven surface	○	○	○	○	○

Section E: Quality of Life

How often are you aware of your hip problem?	**Never** ○	**Monthly** ○	**Weekly** ○	**Daily** ○	**Constantly** ○
Have you modified your lifestyle to avoid activities potentially damaging to your hip?	**Not at all** ○	**Mildly** ○	**Moderately** ○	**Severely** ○	**Totally** ○
How much are you troubled by lack of confidence in your hip?	**Not at all** ○	**Mildly** ○	**Moderately** ○	**Severely** ○	**Extremely** ○
In general, how much difficulty do you have with your hip?	**None** ○	**Mild** ○	**Moderate** ○	**Severe** ○	**Extreme** ○

Lower Extremity Activity Scale

Please read through each description given below, pick the ONE description that best describes your regular daily activity, and put a check in that circle (check one circle only).

- ○ I am confined to bed all day.
- ○ I am confined to bed most of the day except for minimal transfer activities (going to the bathroom, etc.)
- ○ I am either in bed or sitting in a chair most of the day
- ○ I sit most of the day, except for minimal transfer activities, no walking or standing.
- ○ I sit most of the day, but I stand occasionally and walk a minimal amount in my house. (I may rarely leave the house for an appointment and may require the use of a wheelchair or scooter for transportation.)
- ○ I walk around my house to a moderate degree, but I don't leave the house on a regular basis. I may leave the house occasionally for an appointment.
- ○ I walk around my house, go outside at will and walk several blocks at a time.
- ○ I walk around my house, go outside at will and walk several blocks at a time without any assistance (whether permitting).
- ○ I am up and about at will in my house and can go out and walk as much as I would like with no restrictions (whether permitting).

I am up and about at will in my house and outside. I also work outside the house in a:

- ○ Minimally active job
- ○ Moderately active job
- ○ Extremely active job

(Please check the best description of your work level.)

I am up and about at will in my house and outside. I also participate in relaxed physical activity such as jogging, dancing, cycling, or swimming:

- ○ Occasionally (2-3 times per month)
- ○ 2-3 times per week
- ○ Daily

I am up and about at will in my house and outside. I also participate in vigorous physical activity such as competitive level sports:

- ○ Occasionally (2-3 times per month)
- ○ 2-3 times per week
- ○ Daily

Harris Hip Score

Please answer the following questions:

Pain:	
○ None	
○ Slight, occasional, no compromise in activities	
○ Mild pain, no effect on average activities, rarely moderate pain with unusual activity, may take Aspirin	
○ Moderate pain, tolerable but makes concessions to pain. Some limitations of ordinary activity or work. May require occasional pain medication stronger than Aspirin	
○ Totally disabled, crippled, pain in bed, bedridden	
Activities:	
Distance Walked:	**Walking aids:**
○ Unlimited	○ None
○ Six Blocks (30 min)	○ Cane/walking stick for long walks
○ Two or three blocks (10-15 minutes)	○ Cane/walking stick for most of the time
○ Indoors only	○ One crutch
○ Bed and chair only	○ Two canes/walking sticks
	○ Two crutches, walker, or not able to walk
Stairs:	**Limp:**
○ Normally without using a railing	○ None
○ Normally using a railing	○ Slight
○ In any manner	○ Moderate
○ Unable to do stairs	○ Severe, or unable to walk
Shoes/socks:	**Sitting:**
○ With ease	○ Comfortable, ordinary chair for one hour
○ With difficulty	○ On a high chair for 30 minutes
○ Unable to fit or tie	○ Unable to sit comfortably on any chair
Public Transportation:	
○ Able to use public transportation (bus)	
○ Unable to use public transportation (bus)	

ORTHOPEDIC PARTNERS

Date: _____ Date of Injury: _____

Patient: _____ Place of Injury: _____

Provider: _____ Work Related? _____ Yes / _____ No

Account #: _____ Auto Accident: _____ Yes / _____ No

Insurance: _____ ID: _____

Subscriber: _____

If your care is the result of an auto accident, please check one of the below:

_____ I have Med Pay on my Auto Policy
(this means the auto insurance pays as your primary insurance)

_____I have no Auto Med Pay Insurance
(this means personal health insurance pays as your primary insurance. Please supply a statement from your auto carrier that there was no med pay effective at time of the accident)

Are you pursuing legal action against another party? _____ Yes / _____ No

What did you injure? (example: left arm) _____

Attention Pequot Plus members: if your injury is the result of an auto accident and you were the driver, Pequot Plus requires that you submit a copy of the police report to their office.

Give a complete and accurate account of the injury, including <u>how</u> and <u>where</u> it occurred as required by your insurance:

_____

_____

_____

Signature _____ Witnessed _____

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