

Date: _____

Age: _____

Patient Name: _____

Date of Birth _____

Referring Physician: _____ Primary Physician _____

Problem with: Right Hip Left Hip Estimated date first noticed problems: ____/____/____

Was this due to injury? Yes No Was injury work related? Yes No

Currently working? Yes No How did injury occur : _____

Prior Hip surgery? Yes No If yes, list date, procedure and doctor _____

How would you rate your worst pain? 1 (No pain), 2, 3, 4, 5, 6, 7, 8, 9 and 10 (severe pain)

Problem is presently: Worsening Unchanged Improving

The pain is? Constant Intermittent

Location? Groin Thigh Buttocks Anterior Knee
 Lateral to knee Below Knee

Quality? Sharp Dull Burning Throbbing
 Tingling Electric Shocks

Other Complaints? Locking Giving way Back Pain Night Pain
 Stiffness Swelling Weakness Pain arising from chair

Activities which were interfered with include:

Sports Walking Shopping Stair Climbing Sleeping
 Running Gardening Working Other _____

When do Symptoms occur?: Night Morning At Work During Exercise After Exercise
 Other _____

Treatments that have been tried include:

Anti Inflammatory _____ Helped? Not Helped Physical Therapy Helped? Not Helped
 Pain Medications _____ Helped? Not Helped Bracing Helped? Not Helped
 Exercises Helped? Not Helped Crutches/Cane Helped? Not Helped
 Reduced Activity Helped? Not Helped Walker Helped? Not Helped
 Other _____ Helped? Not Helped MRI

Review of Systems: Any Changes since the last visit with the following: Circle & Explain

Weight Loss Mouth/Throat Kidneys/Bladder
 Fevers Heart Skin
 Eyes Lungs Nerves/Anxiety/Depression
 Ears Stomach Bleeding/Clotting
 Nose Bowels Recurrent Infections

Explain: _____

New Medication?: _____

Recent Surgery?: _____

Any Questions for the Dr. Gavin that you would like answered?: _____

Patient Signature: _____

Physician Signature: _____