

Initial Visit Hip

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 Thigh
 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 Waking or Sleeping
- Running Gardening Working Kneeling Squatting Rising from a chair
- Other _____

Treatments that have been tried include:

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

Review of Systems: Please check all that apply for you

- Chest Pain Hypertension Parkinson's Disease Sickle Cell Disease
- Heart Murmur Leukemia Liver Disease Thalassemia/Von Willebrands
- Heart Attack Emphysema/Chronic Bronchi Hearing Loss Hemophilia
- Heart Valve Disease Kidney Failure Poor Vision Stomach Ulcer/Reflux
- Irregular Heart Beat Kidney Stones Cataracts Ulcerative Colitis/Chron's
- Pacemaker Prostate Disease Depression/Bipolar Disorder Hepatitis
- Stroke Incontinence Schizophrenia Psoriasis or Skin Disease
- TIA Seizure Thyroid Disease HIV
- Asthma/Tuberculosis Multiple Sclerosis Adrenal/Pituitary Disease COPD

- Diabetes, controlled with: Insulin Oral Medication Diet
- Cancer, which type/where? _____ Treatment _____
- None of the above Other _____

SECOND OPINION _____

Family History	Yes?	Relationship	Family History	Yes?	Relationship
Arthritis (Specify type)			High Blood Pressure		
Bleeding Problems			Congenital Heart Disease		
Cancer (Specify)			Leukemia		
Diabetes			Liver Disease		
Emotional Problems			Stroke		
Epilepsy/Seizures			Suicide		
Heart Disease			Tuberculosis		