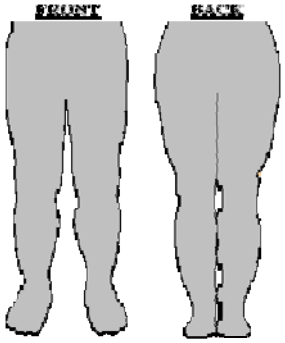
**Fletcher Allen** **Name**:
**Adult Reconstruction Service** **DOB:**
**HIP PAIN HISTORY** Age: _____ **Sex: M F**
(Please complete both pages of this form)

Weight: _____ lbs Height: _____ BMI: _____ Recent weight loss or gain? Yes ___ No ___

Which hip is bothering you? Right ___ Left ___ Both ___
How long has it bothered you? Right ____ Days ____ Months ____ Years ____
Left ____ Days ____ Months ____ Years ____

Occupation: _____ Length of time at this job? Years: ____ Months: ____ Days:___
Previous Job History: _____ Years _____




**DID YOU HAVE A SPECIFIC INJURY? Yes ____ No ____**
If yes, date of injury: __/__/____ Where? _____
Describe how it happened? _____
If no, describe onset: Sudden ____ Gradual ____ At Night ___

**DESCRIBE YOUR HIP PROBLEM/COMPLAINT (circle all that apply)**
__ **Pain Where?** Groin (front) Buttock Thigh Outside of hip area
Other: _____
**Severity?** Occasional Mild Moderate Severe
At Rest Awakes you at night?
**Does the pain go down your leg?** Yes No **Below the ankle?** Yes No
**What activities hurt your hip(s)?**
stairs squatting sitting putting on shoes/socks driving intimacy
**Do you walk with a limp?** Yes No
**Do you walk with a**: Cane Walker Crutches
**How far can you walk?** Unlimited ½ mile 100 yards indoors only
**Other hip symptoms?** swelling redness morning stiffness weather-related pain
__ **Other joint complaints (describe)** _____

**PRESENT ACTIVITY LEVEL: (Check highest level manageable)**
__ Total incapacity
__ Able to do activities of daily living, but unable to participate in activities outside home
__ Able to participate in social activities outside the home, some activities are limited by pain
__ Able to do regular social and recreational activities with occasional pain
__ Able to do all social and recreational activities, including sports without pain

**HAVE YOU HAD THIS PROBLEM/SIMILAR COMPLAINT BEFORE?** (circle) **Yes No**

If yes, who treated you?_____ Which office? _____
When? __/__/____ to __/__/____ Did you have any relief? _____
What were you told your problem was? _____
_____

**HAVE ANY X-RAYS BEEN TAKEN FOR YOUR HIP(S) ?** (circle) **Yes No**

If yes, where were the x-rays taken? _____

When were the x-rays done? _____

**OTHER TESTS:**

| | **Where** | **When** |
|---|---|---|
| Bone Scan | _____ | _____ |
| CT Scan | _____ | _____ |
| MRI Scan | _____ | _____ |
| Arthrogram (dye test) | _____ | _____ |
| Aspiration(fluid removed) | _____ | _____ |
| Biopsy (tissue removed) | _____ | _____ |
| Blood Test(s) | _____ | _____ |

**DESCRIBE ANY TREATMENT YOU HAVE HAD FOR THIS PROBLEM:**

____ Medication(s) Name: _____ dose: _____

_____ _____

____ Physical Therapy Where: _____ When: _____to _____

____ Injection(s) Where were you injected: outside of hip? inside hip joint? (circle)

How many injections: 1 2 3 more than 3 (circle)

____ Surgery Surgeon:_____ When: _____ Where: _____

What was found? _____

_____

**MARK YOUR <u>TYPICAL DAILY</u> PAIN LEVEL ON THIS LINE:**

**"L" for lowest "P" for present "H" for highest**

1 ----------5----------1

No pain Worst possible pain

**CURRENT SPORTS PARTICIPATION:** (circle) Walking Hiking Running Cycling Swimming Canoe/Kayak Skiing Baseball/Softball Basketball Soccer Rugby Tennis Other: _____

**What are your goals for today's visit**? (please write out any questions you have for your Doctor)

_____

_____

_____

_____

Patient signature _____ Staff signature _____ Date __/__/____