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:

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<thead>
<tr>
<th>Test</th>
<th>Where</th>
<th>When</th>
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<tbody>
<tr>
<td>Bone Scan</td>
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<td>CT Scan</td>
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<td>MRI Scan</td>
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<tr>
<td>Arthrogram (dye test)</td>
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<td>Aspiration (fluid removed)</td>
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<tr>
<td>Biopsy (tissue removed)</td>
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<td>Blood Test(s)</td>
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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 TYPICAL DAILY PAIN LEVEL ON THIS LINE:
“L” for lowest  “P” for present  “H” for highest

1 .................................................................................................................. 5
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)

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........................................................................................................................................
........................................................................................................................................

Patient signature ____________________  Staff signature ____________________  Date __/__/____