



Dr. Cheung New Patient Hip Questionnaire: Date _____

Name _____ Age: _____

1. Which hip hurts the most? Right Left
2. Severity of pain from 0-10 scale (0 none, 10 maximum): _____
3. How long have you had pain in the hip? _____ months _____ years
4. Was there an injury? No Yes: Description (include date of injury)

5. Do you have any previous surgeries to the hip? No Yes. Description (include approximate dates):

6. Degree of disability: None Slight/Occasional Mild with no effects on activities
 Moderate but tolerable Marked with serious limitations Totally disabling
7. Type of pain: Sharp Dull/aching Tingling/Electric Burning Shooting throbbing
8. Does pain radiate? Yes No
If so, where does it radiate? Low back Thigh Knee Foot Other: _____
9. Do you have low back pain? Yes No
10. Is the pain worse at night (sleeping) or worse during daytime? Night Daytime
11. Does the pain wake you up at night? No Yes: Frequency is _____ times per night per week
12. What interventions have you had recently for the hip?
 Narcotics Tylenol Steroid injections Anti-inflammatories Physical therapy
Degree of relief from the above: None Minimal Moderate Good
13. Do you use any of the following? Cane Crutches Walker Wheelchair
14. Walking distance: Unlimited _____ minutes Around the mall 2-3 blocks
 Indoors only From bed to chair only
15. I can climb stairs: Easily Ok but need railing Difficult Unable to climb stairs
16. Putting on shoes and socks is: Easy Difficult
17. I can sit comfortably in a chair for: <30 minutes 1 hour As long as I want
18. What aggravates your hip? _____
19. What relieves your hip? _____
20. Please list your occupation(s). If retired, list former occupation(s).
