NewportCare®
MEDICAL GROUP

PATIENT HISTORY
FOR ORTHOPAEDICS

New Patient Hip Questionaire: 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).

_____

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