Advanced Orthopedic
& Sports Medicine Specialists

DR. HUNT'S HIP EVALUATION FORM

Name: _____Date of birth: _____

Who referred you to our office? _____

Who is your primary care provider? _____

Which hip are you seeking evaluation for today? ☐ RIGHT ☐ LEFT ☐ BOTH

If both hips hurt, which is worse? ☐ RIGHT ☐ LEFT ☐ EQUAL

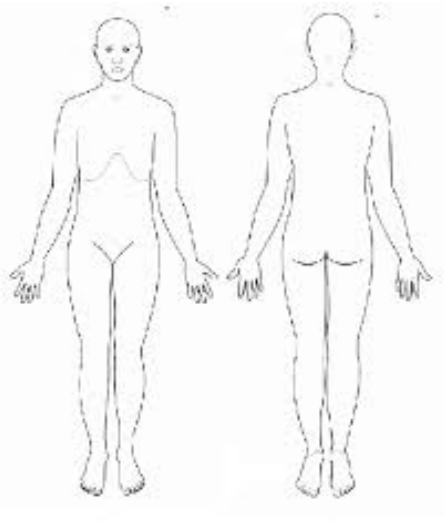
Have you had any prior hip surgery or hip procedures? (please circle side and list procedure below)

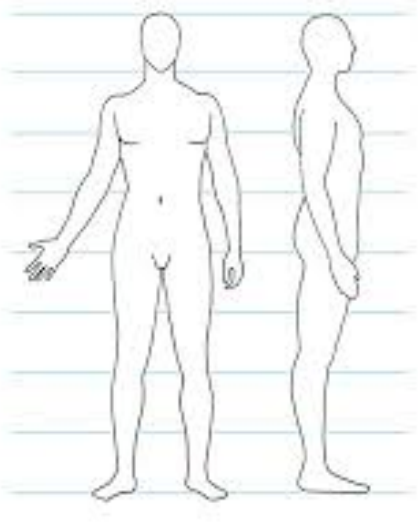
RIGHT LEFT Procedure: _____

RIGHT LEFT Procedure: _____

RIGHT LEFT Procedure: _____

Where does your hip hurt? Be as specific as you can by placing X's on the diagram in the location of your pain. You may place arrows from the X's to relate if there is any radiation of the pain to other locations in your leg.





Do you experience any painful clicking, popping, catching or locking of the hip? YES NO

If so, please explain._____

_____

Does your hip ever feel unstable? (please circle) YES NO

If so, please describe. _____

_____

What activities make your hip pain worse? (please circle all that apply)

WALKING STANDING STAIRS KNEELING/SQUATTING PROLONGED SITTING

OTHER: _____

What have you found that improves your hip pain?

_____

Do you have any knee pain? (please circle) YES NO

If so, please describe: _____

Do you have any numbness or tingling in your legs? (please circle) YES NO

If so, please describe: _____

How far can you walk before your are limited by your hip pain? ____ Block(s) _____ Mile(s) Other: _____

Do you have limited hip motion? YES NO

Do you have trouble with shoes and socks? YES NO

Treatment attempted:

-Have you modified your activities due to your hip pain? YES NO

-Do you exercise on a regular basis? YES NO If so, how often? _____

-Have you attempted to achieve or maintain a normal weight? YES NO

-Have you used any of the following pain/anti-inflammatory medications currently or in the past?

IBUPROFEN (Motrin/Advil) NAPROXEN (Aleve) OTHERS: _____

-Have you undergone any formal physical therapy? YES NO If so, how long? _____

-Have you ever receive a hip injection for treatment of your pain?

-Steroid injection? YES NO If so, how many? _____

-Any other types of injections? YES NO If so, what type of injection? _____

-Where was the injection performed? ☐ Hip joint (from the front) ☐ Hip bursa (from the side)

-If you have received injections in the past, were they effective? YES NO If so, how long? _____

-Please list any other treatments you have used for your hip pain.

_____

_____

Do you have any metal allergies or sensitivities? YES NO

Please list any other pertinent information about your knee complaints not listed above.

_____

_____