



**INSTRUCTIONS:**

This survey asks for your views about your hip problem. This information will help your doctors keep track of how you feel and how well you are able to do your usual activities.

Today's Date Is: \_\_\_/\_\_\_/\_\_\_  
104.49

**SECTION A  
INSTRUCTIONS TO PATIENTS**

**The following questions concern the amount of pain you are currently experiencing in your hip(s). For each situation please enter the amount of pain recently experienced in your hip(s). (Please mark your answers with an "X")**

1. In general, how much pain do you have in your affected hip(s)?
- |                          |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None                     | Slight                   | Mild                     | Moderate                 | Severe                   | Extreme                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

104.171

**QUESTION:** How much pain do you have

104.207

- |                               |                          |                          |                          |                          |                          |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 2. Walking on a flat surface? | None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
|                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Going up or down stairs?   | None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
|                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. At night while in bed?     | None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
|                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Sitting or lying?          | None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
|                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Standing upright?          | None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
|                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Select **one** pain item from questions 2–6 that you most want to improve. (Write the item # here \_\_\_\_\_.)

## SECTION B INSTRUCTIONS TO PATIENTS

The following questions concern the amount of joint stiffness (not pain) you are currently experiencing in your hip(s). Stiffness is a sensation of restriction or slowness in the ease with which you move your joints. (Please mark your answers with an "X")

1. How **severe** is your stiffness **after first wakening** in the morning? 104.173.1
- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
2. How **severe** is your stiffness after sitting, lying or resting **later in the day**? 104.173.2
- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Select **one** stiffness item that you most want to improve. (Write the item # here \_\_\_\_\_.)  
104.173.3

## SECTION C INSTRUCTIONS TO PATIENTS

The following questions concern your physical function. By this we mean your ability to move around and look after yourself. For each of the following activities, please indicate the degree of difficulty you are currently experiencing in your hip(s). (Please mark your answers with an "X")

104.174.1-  
104.174.18

**QUESTION:** What degree of difficulty do you have with

1. Descending stairs?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ascending stairs?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Rising from sitting?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Standing?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Bending to floor?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Walking on flat?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Getting in/out of car?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Going shopping?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Putting on socks/stockings?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Rising from bed?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Taking off socks/stockings?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Lying in bed?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Getting in/out of bath?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Sitting?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Getting on/off toilet?	None	Mild	Moderate	Severe	Extreme
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- |                            |                          |                          |                          |                          |                          |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 16. Heavy domestic duties? | None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
|                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Light domestic duties? | None                     | Mild                     | Moderate                 | Severe                   | Extreme                  |
|                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Select **one** physical function item that you most want to improve.  
(Write the item # here \_\_\_\_.)

104.174.16 -  
104.174.18

Answer the following questions by circling the appropriate number. For each question, please circle only the one best answer. If you are unsure about how to answer a question, please give the best answer you can and make a comment in the right margin.

18. What kind of support do you use when walking? (*circle one number*) 100.468

- None ..... 1
- One cane only for long (30 minutes) walks ..... 2
- One cane ..... 3
- One crutch ..... 4
- Two canes ..... 5
- Two crutches ..... 6
- Walker ..... 7
- Another person ..... 8

19. How long can you walk? (*circle one number*) 104.175

- More than one hour ..... 1
- 31-60 minutes ..... 2
- 11-30 minutes ..... 3
- 2-10 minutes ..... 4
- Less than two minutes or indoors only ..... 5
- Unable to walk ..... 6

20. How much do you limp? (*circle one number*) 104.176

- Not at all ..... 1
- Slightly ..... 2
- Moderately ..... 3
- Severely ..... 4

21. How important was each of the following in your decision to have hip surgery at this time? (*circle one number for each row*)

104.177

	Not a reason	A minor reason	An important reason	A very important reason
Want to reduce the amount of pain I feel	1	2	3	4
Advice from my doctor	1	2	3	4
Want to do more work related to my job	1	2	3	4
Want to participate in recreational or social activities	1	2	3	4
Urging from my family and/or friends	1	2	3	4
Want to be more independent and do more things for myself	1	2	3	4

22. When you are fully recovered from surgery, how limited do you expect to be in your normal daily activities? (*circle one number*)

100.103

- Not limited ..... 1
- Slightly limited ..... 2
- Moderately limited ..... 3
- Very limited ..... 4
- Severely limited ..... 5
- Totally limited ..... 6

23. When you are fully recovered from surgery, how painful do you expect your hip to be? (*circle one number*)

100.104

- Not painful ..... 1
- Slightly painful ..... 2
- Moderately painful ..... 3
- Very painful ..... 4
- Extremely painful ..... 5

24. Will there be someone to help you during your recovery? (*circle one number*)

- No ..... 1
- Yes, available full time ..... 2
- Yes, available most of the time ..... 3
- Yes, available a lot of the time ..... 4
- Yes, available some of the time ..... 5
- Yes, available a little of the time ..... 6

104.178

25. How many months do you think it will be before you feel fully recovered from surgery? *(circle one number)*

- |                               |   |         |
|-------------------------------|---|---------|
| Less than one month.....      | 1 | 100.107 |
| One to three months .....     | 2 |         |
| Four to six months.....       | 3 |         |
| Seven to nine months.....     | 4 |         |
| Ten to twelve months.....     | 5 |         |
| More than twelve months ..... | 6 |         |

26. How would you describe your cigarette smoking habits?  
*(circle one number)*

100.473

- |                     |   |
|---------------------|---|
| Still smoke .....   | 1 |
| Used to smoke ..... | 2 |
| Never smoked .....  | 3 |