

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")

104.171

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"/> |

QUESTION: How much pain do you have

- | | | | | | |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 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"/> |

104.172

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? 104.188.1
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 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**? 104.188.2
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Extreme |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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")

104.189

QUESTION: What degree of difficulty do you have with

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

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*)

- | | | |
|---|---|---------|
| None | 1 | 100.468 |
| 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*)

- | | | |
|---|---|---------|
| More than one hour | 1 | 104.175 |
| 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*)

- | | | |
|------------------|---|---------|
| Not at all | 1 | 104.176 |
| Slightly | 2 | |
| Moderately | 3 | |
| Severely | 4 | |

21. How successful was your hip replacement in allowing you to return to your normal daily activities? (*circle one number*)

- | | | |
|-----------------------------|---|---------|
| Extremely successful | 1 | 104.217 |
| Very successful | 2 | |
| Moderately successful | 3 | |
| Slightly successful | 4 | |
| Not at all successful | 5 | |

22. How successful was your hip replacement in relieving your pain? 100.218
(circle one number)

- Extremely successful 1
- Very successful 2
- Moderately successful 3
- Slightly successful 4
- Not at all successful 5

23. Was someone there 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

104.190

25. How many months was it before you felt fully recovered from surgery? (circle one number)

- Less than one month 1
- 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
- Still recovering 7

101.42

26. How satisfied are you with the results of your hip replacement? (circle one number)

- Very satisfied 1
- Somewhat satisfied 2
- Somewhat dissatisfied 3
- Very dissatisfied 4

100.474