



Orthopaedic Associates of Zanesville

2854 Bell Street Zanesville, Ohio 43701 P: 740-454-3273 F: 740-588-1081 www.orthozane.com

HIP HISTORY

Patient Name: _____ DOB: _____ Date: _____

CHIEF COMPLAINT (Briefly, what brings you here):

Is today's condition a result of an accident? Yes _____ No _____

If "yes", please circle: auto accident work accident other

Which hip? Right or Left

HISTORY OF PRESENT ILLNESS:

- Where is your pain? (e.g. groin, side, buttocks)

- How severe is it? (1-10 scale) _____
- How long have you had it? _____
- Describe the pain (e.g. Dull, Ache, Sharp, Related to weight bearing or certain movements)

- What aggravates the pain? (please circle all that apply):
 - Stairs
 - Twisting/Pivoting
 - Biking
 - Stooping/Squatting
 - Jumping
 - Running
 - Other: _____
- How far can you walk before having hip pain? (circle one)
1 step 10 feet city block no limit
- Do you have pain at night? Yes or No
- Do you have back pain? Yes or No
- Does it travel down your leg? Yes or No
- Do you have numbness or tingling? Yes or No
- Do you limp? Yes or No
- Have you resorted to a cane, walker, or wheelchair? Yes or No



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HIP HISTORY cont'd

- Have you fallen due to a hip condition? Yes or No
- Any history of trauma or injury? Yes or No
If "yes", when and how? _____

- Any previous surgeries to the hip? Yes or No
If "yes", when and what kind? _____
- Prior injections to this hip (Cortisone)? Yes or No
- Do any of the following decrease your pain?

<input type="radio"/> Rest:	Yes	Minimally	No
<input type="radio"/> Ice:	Yes	Minimally	No
<input type="radio"/> Heat:	Yes	Minimally	No
<input type="radio"/> Over the counter meds (Tylenol/Advil)	Yes	Minimally	No
<input type="radio"/> Prescription meds:	Yes	Minimally	No
- Is there anything else that decreases your pain? _____

- Any previous tests, X-rays, MRI's, Bone Scans? _____
- Have you seen any other doctors for this problem? Yes or No
If "yes", who and when? _____
- Have you ever had this problem before or on the other side? Yes or No
If "yes", explain: _____

- Describe your usual daily activity/work activity: (please circle all that apply)
 - Sedentary
 - Walking
 - Active
 - Standing
 - Lifting
 - Climbing
 - Other: _____

- What is your job description? _____
- Do you have a good appetite? Yes or No
- Have you had unexpected weight loss? Yes or No

