Orthopedic Associates, PA
Hip History

Patient's Name:_____ Date:_____

1. Why are you being seen today?_____
2. What were you doing at the time of the injury or onset of pain? _____

   _____
3. When did the pain occur? Immediately ☐Same Day ☐Few Days Later

   ☐That night ☐Next day ☐Gradual Onset
4. Type of pain? ☐Sharp ☐Stabbing ☐Dull ☐Aching ☐Burning

   How often does the pain occur? ☐Constant ☐Intermittent ☐Occasional
5. Does the pain keep you awake at night? ☐Yes ☐No ☐Sometimes
6. Where is the pain located? ☐Buttock ☐Outside Hip ☐Down back of leg to foot

   ☐Groin ☐In the knee ☐Low Back ☐Front of thigh
7. What, if anything, makes the pain better?_____
8. What, if anything, makes the pain worse?_____
9. Do you have difficulty with: Getting in and out of a chair or car? ☐Yes ☐No
10. Can you cross your legs? ☐Yes ☐No
11. Do you have limited motion in your hip? ☐Yes ☐No
12. Have you ever had a problem or injury to your hip in the past? ☐Yes ☐No
13. Were you born with a hip problem? ☐Yes ☐No
14. Have you had previous treatment for this problem ☐Yes ☐No

    If yes, by whom?_____
15. Please list the type of recreational activities you do: _____

    _____
16. Have you had a problem or injury to your hip in the past? ☐Yes ☐No

    What / When _____

    _____
17. Are you taking medication? ☐Yes ☐No

    If so what? _____

    _____

    _____
18. Past Medical History? _____

    _____

    _____