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PATIENT HIP HISTORY FORM

Name: _____

Date of Birth: _____

Which Hip: ☐ **Left** ☐ **Right** ☐ **Both**

Chief Complaint: _____

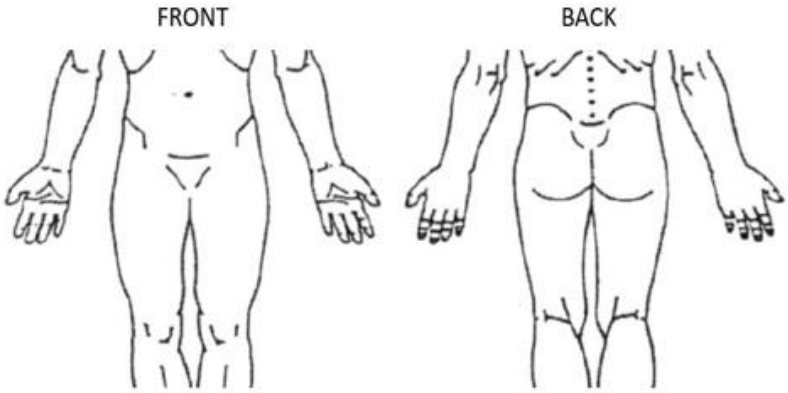
Problems With Your Hip: ☐ **Pain** ☐ **Stiffness** ☐ **Other** _____

Location of Pain: ☐ **Groin** ☐ **Lateral (Side)** ☐ **Other** _____

When Did Your Problems Start: _____

How Did It Start (Ie. Fall/Injury/Sport/Work): _____

Where Do You Have Pain About The Hip?
(Please Indicate on Diagram)



Does Any Position/Activity Make the Pain Better/Worse: _____

Do You Have Hip Pain At Night: _____

Sitting to Standing: ☐ **Yes** ☐ **No** **Getting Out of Car:** ☐ **Yes** ☐ **No**

Do You Feel One Leg is Longer Than the Other: ☐ **Yes** ☐ **No** **Which One:** _____

Do You Have Problems / Pain with Stairs: _____

Do You Have Any Current or History of Lower Back Pain: _____

What Treatment(s) Have You Had So Far: _____

How Far/Long Can You Walk Before the Pain Stops You (Ie 300m/30min): _____

Previous Problems or Surgery With Your Hip:_____

What Activities Do You Want To Return To: _____

Medical Conditions & Previous Surgeries: _____

_____

Do You Have a History of Blood Clots, Clotting Disorders or Bleeding Disorders: _____

Medications / Allergies: _____

_____