PRE OPERATIVE HIP QUESTIONNAIRE – MATER ORTHOPAEDIC OUTCOME REGISTRY

Name:

Date of Birth:

Today's Date:

Operation Date: **Treating Surgeon:**

LEFT HIP ☐ RIGHT HIP ☐ BOTH HIPS ☐ Current Height (cm) _________ Weight (kg) _________

Have you taken any pain relief medication in the past week? ☐ Yes ☐ No

Have you taken any NARCOTIC pain relief medication in the past week? (Narcotic medications include endone, oxycontin, palexia, tramadol, panadeine forte, targin) ☐ Yes ☐ No

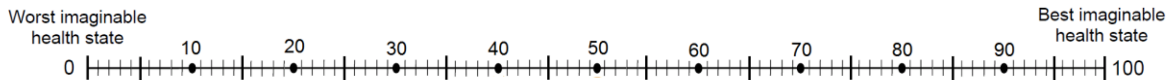
What is the name and dosage in mg of your pain relief medication (s) ____

How many tablets of this medication do you take each day (on average) ____

EQ-5D. By placing a tick, please indicate which statements best describe your own health state today

Problems with Mobility – walking about	☐no	☐some	☐moderate	☐severe	☐ I am unable
Problems with Self -Care - washing or dressing	☐no	☐some	☐moderate	☐severe	☐ I am unable
Problems with Usual Activities (e.g. work, study, housework, family or leisure activities)	☐no	☐some	☐moderate	☐severe	☐ I am unable
Pain/Discomfort	☐ none	☐ slight	☐ moderate	☐severe	☐extreme
Anxiety/Depression	☐ none	☐ slight	☐ moderate	☐severe	☐extreme
	1	2	3	4	5

On the scale below, indicate how good or bad your own health is today, in your opinion.



HOOS JR HIP SCORE Please TICK the most appropriate response to your condition **during the LAST WEEK...**

What amount of **hip pain** have you experienced the last week during the following activities?

Going up or down stairs	☐ none	☐ mild	☐ moderate	☐ severe	☐ extreme
Walking on an uneven surface	☐ none	☐ mild	☐ moderate	☐ severe	☐ extreme

Function. Please indicate the **degree of difficulty** you have had in the last week due to your hip

Rising from sitting	☐ none	☐ mild	☐ moderate	☐ severe	☐ extreme
Bending to floor/picking up object	☐ none	☐ mild	☐ moderate	☐ severe	☐ extreme
Lying in bed (turning over, maintaining hip position)	☐ none	☐ mild	☐ moderate	☐ severe	☐ extreme
Sitting	☐ none	☐ mild	☐ moderate	☐ severe	☐ extreme

On a scale of 0-10, please indicate your average pain over the last 7 days in the **hip** which will be operated on?

0 1 2 3 4 5 6 7 8 9 10

No pain at all — Worst pain imaginable

On a scale of 0-10, please indicate your average pain in your **lower back** over the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

No pain at all — Worst pain imaginable

On a scale of 0 to 10, please indicate your average pain in your **feet** over the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

No pain at all — Worst pain imaginable

On a scale of 0 to 10, please indicate what you expect your average **hip** pain to be in **6 months' time**

0 1 2 3 4 5 6 7 8 9 10

No pain at all — Worst pain imaginable

On a scale of 0 to 10, please indicate what you expect you **general health** to be in **6 months' time**

0 10 20 30 40 50 60 70 80 90 100

Worst health you can imagine — Best health you can imagine

Please tick one box which best describes your expected **mobility** in **6 months' time.**

☐No problems ☐ slight problems ☐ moderate problems ☐ severe problems ☐ unable to walk

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PITTSBURGH SLEEP QUALITY INDEX During the past month.....

How many hours of actual sleep do you get at night? (This may be different than the number of hrs you spend in bed)	☐ >7 hours	☐ 6-7 hours	☐ 5-6 hours	☐ <5 hours
During the past month, how would you rate your sleep quality overall?	☐ Very Good	☐Fairly Good	☐ Fairly Bad	☐ Very Bad

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OXFORD HIP SCORE **During the past four weeks....**

How would you describe the pain you usually have from your hip?

☐None ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe

2. Have you been troubled by pain from your hip in bed at night?

☐ No nights ☐ Only 1 or 2 nights ☐ Some nights ☐ Most nights ☐ Every night

3. Have you had any sudden, severe pain - 'shooting', 'stabbing' or 'spasms' - from the affected hip?

☐ No days ☐ Only 1 or 2 days ☐ Some days ☐ Most days ☐ Every day

4. Have you been limping when walking, because of your hip?

☐ Rarely/never ☐ Sometimes or just at first ☐ Often, not just at first ☐ Most of the time ☐ All of the time

5. For how long have you been able to walk before the pain from your hip became severe?

☐ No pain/>30 min ☐ 16 to 30 min ☐ 5 to 15 min ☐ Around the house only ☐ Not at all – severe on walking

6. Have you been able to climb a flight of stairs?

☐ Yes, easily ☐ With little difficulty ☐ With moderate difficulty ☐ With extreme difficulty ☐ No, impossible

7. Have you been able to put on a pair of socks, stockings or tights?

☐ Yes, easily ☐ With little difficulty ☐ With moderate difficulty ☐ With extreme difficulty ☐ No, impossible

8. After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your hip?

☐ Not at all painful ☐ Slightly painful ☐ Moderately painful ☐ Very painful ☐ Unbearable

9. Have you had any trouble getting in and out of a car or using public transport because of your hip?

☐ No trouble at all ☐ Very little trouble ☐ Moderate trouble ☐ Extreme difficulty ☐ Impossible to do

10. Have you had any trouble with washing and drying yourself because of your hip?

☐ No trouble at all ☐ Very little trouble ☐ Moderate trouble ☐ Extreme difficulty ☐ Impossible to do

11. Could you do the household shopping on your own?

☐ Yes, easily ☐ With little difficulty ☐ With moderate difficulty ☐ With extreme difficulty ☐ No, impossible

12. How much has pain from your hip interfered with your usual work (including housework)?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Greatly ☐ Totally

13. Do you have any problems with your other hip? ☐ Yes ☐ No
14. Do you have any problems walking for other reasons (eg pain from other joints, back pain, chest pain, or other medical conditions)? ☐ Yes ☐ No