TOSH Hip Preservation
The Orthopedic Specialty Hospital
5848 South Fashion Blvd
Murray Utah 84107

Patient Name: ____________________________________ **Date:** __________ **Age:** ______ **Gender:** M / F

Occupation: ____ Are you currently working: YES / NO

Injured doing: Insidious or Unsure / Sports / Work / Auto Date: _____/______/______

Side: Left / Right / Bilateral **Job Related Injury:** YES /NO **Duration of Symptoms:** _______wk/mo/yr

Are you currently taking medications for your hip pain? YES / NO List: ___________________________

Activity Level

1. Prior to hip pain: Sedentary / Recreational / Competitive / Collegiate
2. Sport/ Hobbies: ____

Treatment / Imaging

1. Have you had any of the following? Please check all that apply

   ___ X-rays ___ MRI ___ Physical Therapy

   ___ Injections (hip joint) ___ Anti-inflammatories ___ Activity Modification

2. If you have seen physical therapy, how long did you participate in a formal therapy program?
   a. ____ days ____ weeks _____ months b. Did it help? ____ Yes ____No

(For the Next 5 questions, please circle all that apply)

Symptoms: Pain Weakness Instability/Dislocation Stiffness Swelling
Buckling Locking Grinding Clicking Catching

Location: Groin Lateral Hip Buttocks Hamstrings Back

Describe your symptoms: Sharp Ache Constant Intermittent Burning

What causes pain: Walking Stairs Running Squatting Pivoting / Twisting
Sitting With Knee Bent Sitting Prolonged W/ Hip Flexed Lifting Objects
Other:____________________________

What decreases your pain? Nothing Rest Activity modification Meds
Other: ___________________________________

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? __ Not at all __ Somewhat difficult ___ Very Difficult __ Extremely difficult

Over the past two weeks, have you been bothered by any of the following problems?

1. Little interest in doing things?
   0=Not at all 1= Several days 2=More than ½ the days 3= Nearly everyday
2. Feeling down, depressed, or hopeless?
   0=Not at all 1= Several days 2=More than ½ the days 3= Nearly everyday

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MEDICAL HISTORY FORM

Email Address: ______________________________

Primary Care Physician:______________________

Who Referred you to us:______________________

Height:__________ ft _______ in

Weight: __________lbs

Past Medical History O None

Do you Have any of the Following Conditions? (check all that apply)

O Diabetes	O High Blood Pressure
O Heart Disease	O High Cholesterol
O Stroke	O Kidney Disease
O Thyroid Disease	O Hepatitis
O Lung Disease	O AIDS/HIV

O Chronic Obstructive Pulmonary Disease

O Obstructive Sleep Apnea

If yes, Do you use a CPAP? O Yes O No

O Blood Clots

Was it in the lung? O Yes O No

Is there a Family History of Blood Clots?

O Yes O No If yes, who?_____________

Past Surgical History O None

____

____

____

____

Current Medications/Dosage O None (or attach sheet)

____

____

____

____

Drug/Other Allergies O No Known Allergies

____

____

____

Social History

Do you use Tobacco? O Yes O No O Quit

Do you Drink Alcohol O Yes O No

If yes, how many drinks per week ___________

How do you sleep at night?

O Fine/No issues O With Difficulty

O Only with Medications

Have you ever had an addiction problem?

O Yes O No If yes, what? ____________________

Review of Systems:

Please Check Circle if you (1) have or have had in the past AND/OR (2) if you are being treated for:

Constitutional	Gastrointestinal	Respiratory	Cardiovascular
O Weight Gain	O Heart Burn	O Asthma	O Angina/Chest Pain
O Fatigue	O Vomiting Blood	O Shortness of Breath	O Heart Attack
O Trouble Sleeping	O Stomach Ulcers	O Cough	O Heart Murmur
O Depression	O Blood Stools	O Pulmonary Embolus	O Anemia
O Cancer	O Liver Disease	O Cough up Blood	O Blood Clot
O Overweight	O Constipation		O Easy Bleeding/Bruising
	O Stomach Pain		

Joint Problems	Neurological	Endocrine	Other
O Rheumatoid Arthritis	O Numbness	O Diabetes	O Alcoholism
O Gout	O Seizures	O Thyroid Disease	O Drug Addiction
O Inflammatory Arthritis	O Headaches	O Adrenal Disease	O Kidney Disease
O Lyme Disease	O Anxiety		

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iHOT
INTERNATIONAL HIP OUTCOME TOOL

MRN_______________________________

NAME_______________________________

DOB_______________ DATE_______________
Left Hip _______________ Right Hip _______________

INSTRUCTIONS

- These questions ask about the problems you may be experiencing in your hip, how these problems affect your life, and the emotions you may feel because of these problems.
- Please indicate the severity by marking the line below each question with a slash.

>> If you put a mark on the far LEFT, it means that you feel you are **significantly impaired**. For example:

SIGNIFICANTLY IMPAIRED ___/____ NO PROBLEMS AT ALL

>> If you put a mark on the far RIGHT, it means that you **do not think that you have any problems** with your hip. For example:

SIGNIFICANTLY IMPAIRED ____/___ NO PROBLEMS AT ALL

>> If the mark is placed in the middle of the line, this indicates that you are moderately disabled, or in other words, between the extremes of 'significantly impaired' and 'no problems at all'. It is important to put your mark at either end of the line if the extreme descriptions accurately reflect your situation.

>> Please let your answers describe the typical situation in the last month.

If the activity is one you don't participate in, imagine how your hip would feel if you did.

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1 - Overall, how much pain do you have in your hip/groin?

Extreme Pain ____ No Pain At All

2 - How difficult is it for you to get up and down off the floor/ground?

Extremely Difficult ____ Not Difficult At All

3 - How difficult is it for you to walk long distances?

Extremely Difficult ____ Not Difficult At All

4 - How much trouble do you have with grinding, catching or clicking in your hip?

Severe Trouble ____ No Trouble At All

5 – How much trouble do you have pushing, pulling, lifting or carrying heavy objects?

Severe Trouble ____ No Trouble At All

6 – How concerned are you about cutting/changing directions during your sport or recreational activities?

Extremely Concerned ____ Not Concerned At All

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7 - How much pain do you experience in your hip after activity?

Extreme Pain ______________________________ No Pain At All

8 - How concerned are you about picking up or carrying children because of your hip?

Extremely Concerned ______________________________ Not Concerned At All

9 - How much trouble do you have with sexual activity because of your hip?

Severe Trouble ______________________________ No Trouble At All

10 - How much of the time are you aware of the disability in your hip?

Constantly Aware ______________________________ Not Aware At All

11 - How concerned are you about your ability to maintain your desired fitness level?

Extremely Concerned ______________________________ Not Concerned At All

12 - How much of a distraction is your hip problem?

Extreme Distraction ______________________________ No Distraction At All

PAIN LEVEL

Current pain: _____ / 10 Highest in last 24 hours: ___/10 Lowest in last 24 hours: ____/10

PLEASE INDICATE HOW LONG YOU CAN TOLERATE EACH OF THE FOLLOWING:

Walk: _____ mins / hours Stand: ___ mins / hours Sitting: ___ mins / hours

iHOT 12 Score: _________/100