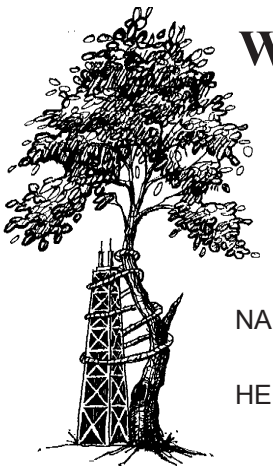


# WINDY CITY ORTHOPEDICS & SPORTS MEDICINE

2617 W. Peterson Avenue Chicago, Illinois 60659
Toll Free 877-549-4490 Suburban 847-475-0200 Chicago 773-743-1981

TODAY'S DATE _____/_____/_____

## PATIENT INFORMATION QUESTIONNAIRE: HIP

NAME _____
FIRST MIDDLE LAST

HEIGHT _____ WEIGHT _____ AGE _____

**I AM RIGHT HANDED I AM LEFT HANDED** (Please Circle)

**WHAT KIND OF WORK DO YOU DO?** (Please Circle) Construction Desk Job Driving Teacher
Executive/Professional Factory Homemaker Retired Sales Student

Other (Please List) _____

**IF YOU ARE <u>NOT</u> WORKING NOW, WHEN DID YOU LAST WORK?** _____/_____/_____

**DOES IT REQUIRE LIFTING? HOW OFTEN DO YOU LIFT THESE WEIGHTS?** (Please Circle)
None 10 lbs. or less 10-50 lbs. 50-100 lbs More than 100 lbs.
Rarely Frequently Constantly

**AS PART OF YOUR WORK DO YOU COMMONLY?** (Please Circle All Those That Apply)
Squat Push Pull Lift Overhead Climb Ladders/Stairs Reach Bend Stoop

**IS THIS A WORKMAN'S COMPENSATION CASE?** (Please Circle) Yes No

Company Name _____ Company Phone (_____)_____

Company Address _____
STREET CITY STATE ZIP

**IS THIS A LEGAL OR THIRD PERSON LIABILITY CASE?** (Please Circle) Yes No

Lawyer's Name _____ Lawyer's Phone (_____)_____

Lawyer's Address _____
STREET CITY STATE ZIP

**WHICH JOINT(S) ARE YOU HAVING TROUBLE WITH?** (Please Circle Those That Apply)
Right: Shoulder Elbow Wrist Hand Fingers Hip Knee Ankle Foot Toes
Left: Shoulder Elbow Wrist Hand Fingers Hip Knee Ankle Foot Toes
Back Left Buttock Right Buttock Left Groin Right Groin Left Thigh Right Thigh
Other (Please List) _____

_____

**PLEASE <u>CIRCLE</u> YOUR <u>ONE MAJOR</u> COMPLAINT !** PLEASE <u>CHECK</u> (✔) ANY OTHER COMPLAINTS

| | | |
|---|---|---|
| Aching/Soreness | Limping | Locking/Catching |
| Popping or Crunching Noises | Weakness | Stiffness |
| Back, Buttock or Hip Pain | Leg, Calf, or Foot Pain | Driving/Sitting |
| Leg Numbness | Standing | Footdrop |

Difficulty With: Lifting Putting on Clothes/Shoes Stairs/Ladders Cutting Toenails Getting Up From a Chair
Limited: Hip Motion Walking Sports/Running Activities Work

Any Other Complaints _____

_____

**HAVE YOU EVER HAD A HIP, BUTTOCK OR A LOW BACK INJURY OR PAIN?** YES NO (See Last Page for Surgery)
WHEN?_____

_____

**ONSET OF THE PROBLEM:**

Suddenly But No Known Injury: On ____/____/____

_____ Days Ago _____ Weeks Ago _____ Months Ago _____ Years Ago

An Injury : On ____/____/____

_____ Days Ago _____ Weeks Ago _____ Months Ago _____ Years Ago

I Don't Know When _____ Gradually Since _____

Other_____

**HAVE YOU MISSED WORK/PRACTICE BECAUSE OF YOUR BACK, BUTTOCKS OR HIP?** Yes No

How long have you been off work? ____ days ____weeks ____ months _____ Since the Injury

If you have returned to work, when did you return? ____week(s ) ago ___ month(s) ago On ____/____/____

**HAVE YOU BEEN ON LIGHT OR LIMITED DUTY BECAUSE OF YOUR BACK, BUTTOCKS OR HIP?** Yes No

**INJURED WHILE:**(Please Circle All Those That Apply)

| | | |
|---|---|---|
| Falling | Hit By Object | Running/Jumping |
| Hit By Another Player | Slipped on Ice/Water/Oil | Tripping |
| Noncontact | Pulling/Pushing | Reaching |
| Twisting | Vehicle Accident | Ankle/Foot was run Over |

Other_____

_____

**INJURED DURING:**(Please Circle )

| | | |
|---|---|---|
| Aerobics | Basketball | Baseball |
| Bicycling | Football | Handball |
| Racquetball | Running | Soccer |
| Skiing | Tennis | Volleyball |

Other _____

_____

**IF THIS WAS AN INJURY ON THE JOB, PLEASE FILL OUT THIS SECTION**

Injury At Work On _____ Time of Day _____ AM PM

Was any equipment, machinery and/or object involved in the accident? **Yes** **No**

If yes,please explain _____

_____

Was the accident reported to your supervisor and/ or employer at the time of the injury? **Yes** **No**

**IF THIS WAS A MOTOR VEHICLE ACCIDENT,PLEASE FILL OUT THIS SECTION**

Vehicle Accident On _____/_____/_____ Time of Day _____ AM PM

Were You? (Please Circle) Driver Passenger Pedestrian Wearing a Seatbelt? **Yes** **No**

Did you strike your head or lose consciousness? **Yes** **No**

If you were passenger,what was your position in the vehicle? _____

What kind of vehicle(s) was/were involved in the accident? (Please circle your type of vehicle and place a check (✔) over the other) Truck Van Car Motorcycle

Other _____

Was the collision?: Rear end Headon "T" Type Sideswipe Struck on the Left Struck on the Right

Multiple Vehicle "Daisy Chain" Other _____

_____

Was your vehicle moving when it was struck? Yes No How fast was it going? _____

Was the accident reported to the police? **Yes** **No**

What was the weather? _____

Did your vehicle strike another vehicle or object? Yes No Please Describe: _____

_____

Other _____

_____

_____

IF YOU ARE EXPERIENCING **PAIN:** PLEASE ANSWER THIS SECTION.

IF NOT, PLEASE CIRCLE **NO PAIN** AND SKIP TO THE NEXT PAGE

Overall, Since It Started, Is Your Pain? (Please Circle) Getting Better Getting Worse Staying the Same

Overall, How Much is the Pain Better or Worse ? (Please Circle) 0% 10% 25% 50% 75% 90%

On Average, I have _____% Good Days _____ % Bad Days _____ % Average Days

**LOCATION OF THE PAIN** (Please Circle The Major Pain and Check ( ✔ ) Any OthersThat Apply)

| | | |
|---|---|---|
| Back Only | Back and Hip/Leg | Hip/Leg Without Back Pain |
| Anterior Thigh | Posterior Thigh | Lateral Thigh |
| Groin | Abdomen | Tailbone |

**THE PAIN GOES TO:**

| | | |
|---|---|---|
| Lateral Hip | Buttock | Tailbone |
| Anterior Thigh | Posterior Thigh | Lateral Thigh |
| Groin | Abdomen | Tailbone |
| Back of the Knee | Calf | Anterior Shin |
| Top of the Foot | Sole of the Foot | Big Toe |

WHERE DID YOUR PAIN START? _____

WHERE DID YOUR PAIN SPREAD?(If Anywhere) _____

**FREQUENCY OF PAIN:** (Please Circle All Those That Apply)

| | | |
|---|---|---|
| Recent Onset | Occassionally | Irregularly |
| Unpredictable | Some Days | Most/ Every Day |
| Constantly | At Work | Most/Every Night |
| Even When Resting | With or After Activity/Sports | Initially But Not Now |
| Getting More Frequent | Getting Less Frequent | Frequency is Unchanged |

Other _____

***TIME OF DAY WHEN THE PAIN OCCURS:*** (Please Circle The MajorTime of Day and Check ( ✔ ) Any OthersThat Apply)

| | | |
|---|---|---|
| Morning | Late in the Day | Evening |
| Unpredictable | Irregular | Good & Bad Days |
| At Work | All Day/Constant | No Apparent Pattern to the Pains |
| Interrupts My Sleep | Other _____ | |

**HOW OFTEN DO YOU WAKE UP AT NIGHT OR HAVE DIFFICULTY GOING TO SLEEP?**

| | | |
|---|---|---|
| Never | Rarely/Sometimes | Most Nights |
| Every Night | I Can Sleep But Only When I Take Medicine | I Can't Sleep Even When I Take Medicine |

**BECAUSE OF MY HIP/BUTTOCKS/LEG PAIN I HAVE TO SLEEP :** (Please Circle)

| | | |
|---|---|---|
| I Have No Difficulty Sleeping | On My Back | On My Stomach |
| On the Affected Side | Sitting Up | Without Sheets Touching My Legs/Feet |

**THE PAIN IS:**

| | | |
|---|---|---|
| Sharp/Knifelike | Dull | Aching |
| Electric Shock | Burning | Continuous |
| Worst in the Morning | Worst in the Evening | Soreness but not pain |

Other _____

**PAIN MADE WORSE WHEN:**(Please Circle All Those That Apply)

| | | |
|---|---|---|
| Nothing Specific | Walking | Standing |
| Running | Sports | Jumping |
| Stairs/Ladders | Driving or Sitting | Housework/Yardwork |
| Squatting/Kneeling | Carrying Objects | Hills/inclines/uneven ground |
| Weather Changes | Pulling/Pushing | Coughing/Sneezing |

Other _____

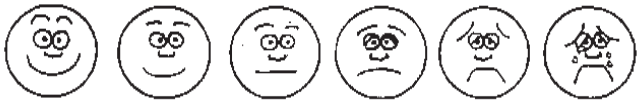
**PAIN RELIEVED BY:** (Please Circle All Those That Apply)

| | | |
|---|---|---|
| Nothing | Rest | Using a Walker/Crutches/a Cane |
| Activity | Heat | Cold/Ice |
| Medicine | Cortisone Injection | Moving the Hip |
| Orthotics/Arch Supports | Wide Shoes | Prescription Shoes |
| Physical Therapy | Avoiding High heels | Wearing sandals/house slippers |

**DO YOU HAVE HIP/BUTTOCKS/LEG PAIN WITH LIFTING:**

| | | |
|---|---|---|
| Telephone Book or 1 Pint of Milk (1-2 lbs.) | Yes | No |
| Sack of Flour or 1 Gallon of Milk (5-10 lbs.) | Yes | No |
| A Small Child (25-50 lbs.) | Yes | No |
| 50-100 lbs. | Yes | No |
| More Than 100 lbs | Yes | No |

**PLEASE CIRCLE THE NUMBER THAT CORRELATES BEST WITH HOW FAR YOU ARE FROM NORMAL TOWARD THE WORST POSSIBLE SITUATION YOU CAN IMAGINE OR HAVE EVER SUFFERED**



0 1-2 3-4 5-6 7-8 9-10

0 = No pain or limitation at all. 10 = The worst possible pain or limitation that you can ever imagine.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| How bad is your pain today? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| How bad is the pain at the worst its ever been? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| How bad is the pain at the best its ever been? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Does the pain interfere with your lifestyle? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Does the pain interfere with your work? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Do you have pain lying in bed or at rest? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## NONPAIN SYMPTOMS/COMPLAINTS

**MAXIMUM WEIGHT YOU CAN PUSH/PULL:** None 25-50 lbs. 100 lbs. More than 100 lbs.

**MAXIMUM WEIGHT YOU CAN CARRY:** (Please Circle) Weight of the Arm Only

Brief Case (5-10 lbs.) Shopping Bag (10-15 lbs.) Suitcase (25-30 lbs.) More Than 50 lbs.

**HIP RANGE OF MOTION:** (Please Circle All those That Apply)

Normal Can't Lift Hip Up Can't Extend Hip Back

Can't Twist Hip "Out" Can't Twist Hip "In" Can't Touch One Heel to the Other Knee

**MOBILITY OF THE HIP:** (Please Circle All those That Apply)

Able to Walk Normally Able to Walk With a Limp Able to Run Normally

Unable to Run Unable to Walk Without a Cane, Crutches,Brace or Walker

How Often Do You Limp or Need an Aid to Walk? Daily Once a Week Once a Month

Other _____

**MAXIMUM TIME YOU COULD SIT IN ONE PLACE IF YOUR LIFE DEPENDED ON IT!** (Please Circle)

Less than 15 Minutes 15-30 Minutes 30-60 Minutes 1-2 Hours Unlimited

**MAXIMUM TIME YOU COULD STAND IN ONE PLACE-IF I PUT A GUN TO YOUR HEAD!** (Please Circle)

Less than 15 Minutes 15-30 Minutes 30-60 Minutes 1-2 Hours Unlimited

**MAXIMUM DISTANCE YOU COULD WALK-IF I PUT A GUN TO YOUR HEAD!** (Please Circle)

From Bed to Wheelchair Across the Room Less Than 1 Block

1 to 4 Blocks 4 Blocks to 1 Mile _____ Miles/Unlimited

Could you walk as far if you could not use an aid such as a cane or crutches? YES NO

**AIDS TO WALKING CURRENTLY IN USE:** (Please Circle All those That Apply)

No Aids Necessary Brace Cane Crutches Walker Wheelchair

Could you go as far if you could not use an aid such as a cane or crutches? YES NO

**MAXIMUM NUMBER OF STAIRS THAT YOU CAN CLIMB-IF I PUT A GUN TO YOUR HEAD!** (Please Circle)

None A Few Steps 1/2 Flight 1 Flight 2 or More Flights I Need the Railing

**DO YOU HAVE WEAKNESS IN THE LEGS?** YES NO

Where?_____

**DO YOU FEEL CRUNCHING, GRINDING, SNAPPING, POPPING, GRATING OR "FUNNY NOISES"?** (Please Circle)

Never Noticeable When Walking I Can Feel Them I Can Hear Them

Where?_____

ARE THE "NOISES" PAINFUL? YES NO

**DO YOU HAVE STIFFNESS IN THE HIP/BUTTOCKS/LEG?** (Please Circle All those That Apply)

None
After Activity or Sports
In the Morning
Always
When Sitting/Driving
End of the Day
Other _____

_____

**DO THE HIP, BUTTOCKS, LEGS or FEET SWELL?** (Please Circle All Those That Apply)

Never
Frequently/Daily
Worst in the AM PM
Originally, But Not Since
Doesn't Ever Go Away - Constant
After Popping Out or Dislocating
Weekly
When the Weather is Bad
Only After Exercise or Use of the Joint
Other_____

**DO YOU HAVE NUMBNESS,TINGLING, OR "PINS AND NEEDLES"?** (Please Circle All those That Apply)

NONE
At Night
Funny Feelings
At First But Not Now
Numbness/Tingling
Burning
Constantly
Pins & Needles
Where?_____

**ACTIVITIES YOU CAN <u>NOT</u> DO BECAUSE OF THE HIP/BUTTOCKS/LEG :** (Please Circle All those That Apply)

None
Put on Clothes/Shoes
Wear High heels
Running
Climb Stairs/Ladders
Wear Tight Shoes
Jumping
Walking
Walk on Uneven Ground
Sports
Standing
Shopping
Housework
Work at my job
Yard Work
Sleep
Lifting
Sitting/Driving
Standing
Squatting Carying
Putting on Shoes or Socks
Other _____

I have had to quit some nonsporting recreational activities I enjoy (Please List) _____

_____

WHICH SPORTS DO YOU (OR WOULD LIKE TO) PARTICIPATE IN? ARE LIMITED IN THEM? (Please List)

_____

HAVE YOU OR DO YOU PARTICIPATE IN COMPETITIVE SPORTS AND AT WHAT LEVEL? (PleaseList)

_____

HAVE YOU EVER BROKEN A BONE, DISLOCATED A JOINT OR HAD ANY OTHER SERIOUS ORTHOPEDIC INJURY THAT DID NOT REQUIRE SURGERY? (Please List and Date Each) _____

_____

**HAVE YOU TAKEN ANY MEDICATIONS FOR THE PAIN?** YES NO

(Please <u>Circle</u> Your CURRENT Medications and <u>Check</u> ( ✔ ) Any OthersThat You Have Taken in the Past)

| <u>Pain Medication</u> | <u>Antiinflammatory Drugs</u> | | <u>Muscle Relaxants/Neuro Drugs</u> |
|---|---|---|---|
| Darvocet-N-100(propoxyphene) | Motrin/Ibuprofen/Advil | Daypro(oxaprozin) | Dantrium(dantrolene) |
| Tylenol #3 (codeine) | Aspirin | Clinoril (sulindac) | Flexeril (cyclobenzaprene) |
| Vicodin/Norco (hydrocodone) | Naprosyn(Aleve) | Lodine(etodolac) | Skelaxin(metaxalone) |
| Oxycontin/Oxycodone | Celebrex (celecoxib) | Limbrel | Soma (carisoprodal) |
| Percodan (oxycodone) | Mobic (meloxicam) | Indocin(indomethacin) | Robaxin(methocabamol) |
| Tylenol (acetaminophen) | Voltaren(diclofenac) | Relafin(nabumetone) | Neurontin (gabapentin) |
| Ultram (tramadol) | Feldene (piroxicam) | Nalfon (fenoprofen) | Lyrica(pregabalin) |
| Duract (bromfenac) | Trilisate (trisalicylate) | Glucosamine | Requip (ropinorole) |

Other _____

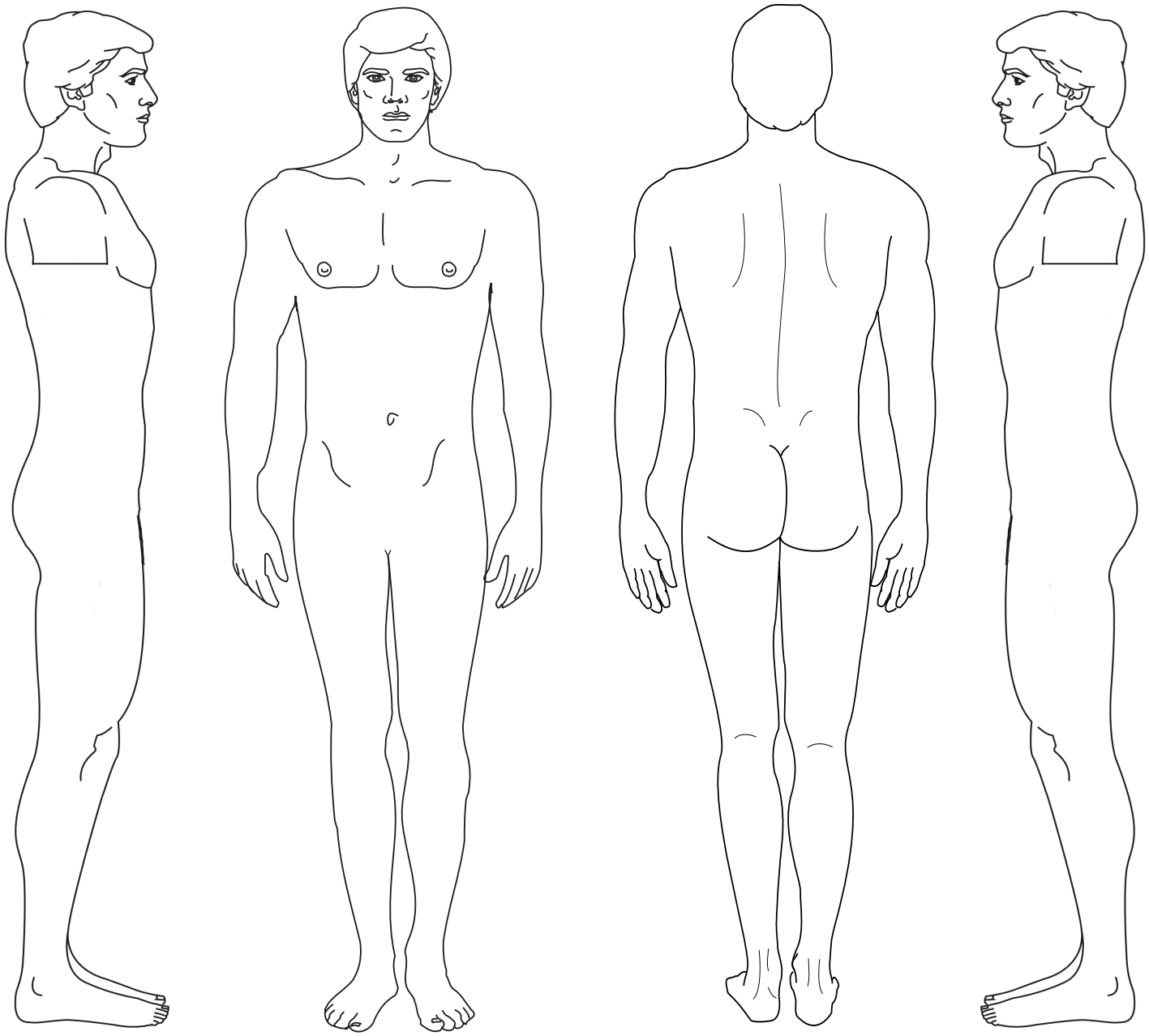
Have you ever had a Cortisone injection or a Prednisone/Medrol dose pack? Yes No How Many? 1 2 3 4 5 >5

Do you use any Herbal Medicine? _____

**DOES THE MEDICATION HELP?** Yes No Only A Little Bit

**WHERE IS YOUR PAIN?** (Please mark on the drawings where you feel the specific type pain or sensation)

Burning [XXXX] Throbbing [✔✔✔✔] Sharp [//////////] Aching [●●●●●] Numbness [*****]



Right Front Back Left

**WERE YOU TREATED FOR THIS PROBLEM BY YOUR FAMILY PHYSICIAN?** YES NO

Name_____ When _____

Diagnosis _____ Treatment _____

**WERE YOU TREATED FOR THIS PROBLEM BY AN ORTHOPEDIC SURGEON?** YES NO

Name_____ When _____

Diagnosis_____ Surgery (See Below)

**WERE YOU TREATED FOR THIS PROBLEM BY A CHIROPRACTER OR NAPROPATH?** YES NO

Name_____ When _____

Diagnosis _____ Treatment _____

**DID YOU EVER HAVE X-RAYS TAKEN OF YOUR HIP/BUTTOCKS/LEG?** YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

**DID YOU HAVE AN ARTHROGRAM (dye test) DONE?** YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

**DID YOU HAVE A CAT SCAN OR MRI DONE?** YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

**WERE YOU TREATED FOR THIS PROBLEM IN AN EMERGENCY ROOM?** YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

**HAVE YOU EVER HAD PHYSICAL THERAPY (PT) OR A BRACE?** YES NO

Name _____ When _____

Diagnosis _____ Treatment _____

**HAVE YOU EVER HAD SURGERY FOR YOUR HIP/BUTTOCKS/LEG?** YES NO

#1 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

#2 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

#3 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____

#4 When _____ Hospital _____

Open Surgery_____ Arthroscopic Surgery _____ Doctor _____

Procedure _____

Results_____



**THANK YOU FOR PATIENCE IN FILLING OUT THIS FORM!**