OLYMPIA ORTHOPAEDIC ASSOCIATES

HIP / THIGH HISTORY FORM

Patient Name: ____________________ **Date:** ____________

1. Who referred you for this problem? ____________________
2. Nature of your hip/thigh problem. (be specific as you can) ____________________

   ____________________ Right or Left
3. How long have you had this problem? ____________________
4. Was there a specific injury? Yes / No. If yes:

   How did the injury occur? ____________________

   When was the injury? ____________________

   Where did it occur? Home Work Sports Auto Accident Other ____________
5. Is the problem work related? Yes / No If yes, has an L & I claim been filed? Yes / No

   Are you still working? Yes / No Light duty or Regular duty? Full time or Part time

   If no, when did you last work? ____________________
6. Current Symptoms:

   Pain? Yes / No Location ____________________

   Severity: 1 2 3 4 5 6 7 8 9 10

   Mild Moderate Severe

   Circle what aggravates pain.

   Walking/ Standing Stairs Squatting/ Kneeling Pivoting/ Twisting Sitting

   Putting on Socks & Shoes What relieves pain? ____________________

   Associated Symptoms

   Pain at night? Yes / No Numbness in legs? Yes / No Stiffness? Yes / No

   Weakness in legs? Yes / No Locking sensation? Yes / No

   Catching or Grinding sensations? Yes / No
7. What treatment have you tried? ____________________

   Ice? Yes / No Heat? Yes / No Tylenol? Yes / No

   Anti-inflammatories? Yes / No Which ones? ____________________

   Cane? Yes / No Walker? Yes / No Home Exercises? Yes / No

   Physical Therapy? Yes / No Crutches? Yes / No Other ____________________
8. Have you had x-rays? Yes / No Where? ____________ When? ____________

   Other studies? Yes / No (CT scans/ MRI) Where? ____________ When? ____________
9. What activities/ exercises do you regularly participate in? ____________________

   Are you still able to participate? Yes / No