Orthopaedic Associates of Zanesville
2854 Bell Street Zanesville, Ohio 43701 P: 740-454-3273 F: 740-588-1081 www.orthozane.com

HIP HISTORY

Patient Name:_____ **DOB:**_____**Date:**_____

CHIEF COMPLAINT (Briefly, what brings you here):

_____

_____

Is today's condition a result of an accident? ***Yes*** _____ ***No*** _____

If "yes", please circle: ***auto accident*** ***work accident*** ***other***

Which hip? **Right or Left**

HISTORY OF PRESENT ILLNESS:

- Where is your pain? (e.g. groin, side, buttocks)

  _____

  _____
- How severe is it? (1-10 scale) _____
- How long have you had it? _____
- Describe the pain (e.g. Dull, Ache, Sharp, Related to weight bearing or certain movements)

  _____

  _____
- What aggravates the pain? (please circle all that apply):
  - Stairs
  - Twisting/Pivoting
  - Biking
  - Stooping/Squatting
  - Jumping
  - Running
  - Other:_____
- How far can you walk before having hip pain? (circle one)
  1 step 10 feet city block no limit
- Do you have pain at night? Yes or No
- Do you have back pain? Yes or No
- Does it travel down your leg? Yes or No
- Do you have numbness or tingling? Yes or No
- Do you limp? Yes or No
- Have you resorted to a cane, walker, or wheelchair? Yes or No

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HIP HISTORY cont'd

- Have you fallen due to a hip condition? Yes or No
- Any history of trauma or injury? Yes or No
  If "yes", when and how? _____
  _____
- Any previous surgeries to the hip? Yes or No
  If "yes", when and what kind? _____
- Prior injections to this hip (Cortisone, injection under fluoroscopy)? Yes or No
- Do any of the following decrease your pain?
  - Rest: Yes Minimally No
  - Ice: Yes Minimally No
  - Heat: Yes Minimally No
  - Over the counter meds (Tylenol/Advil) Yes Minimally No
  - Prescription meds: Yes Minimally No
  - Formal physical therapy Yes Minimally No
    When? _____ How long? _____
  - Home exercises Yes Minimally No
    When? _____ How long? _____
- Is there anything else that decreases your pain? _____
  _____
- Any previous tests, X-rays, MRI's, Bone Scans? _____
- Have you seen any other doctors for this problem? Yes or No
  If "yes", who and when? _____
- Have you ever had this problem before or on the other side? Yes or No
  If "yes", explain: _____
  _____
  _____
- Describe your usual daily activity/work activity: (please circle all that apply)
  - Sedentary
  - Walking
  - Active
  - Standing
  - Lifting
  - Climbing
  - Other:_____
- What is your job description? _____
- Do you have a good appetite? Yes or No
- Have you had unexpected weight loss? Yes or No

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HIP HISTORY cont'd

CURRENT MEDICATIONS (include non-prescription meds and herbal supplements, etc.
14 medication(If more than s, please list on a separate sheet)

Name of Medication Dose How Often?	Name of Medication Dose How Often?

ALLERGIES:
Medications None _____ Yes _____
(Please describe)
_____
_____

Latex None _____ Yes _____
Metal None _____ Yes _____