**Name**: _____

**Account**: _____ **Date**: _____

# HIP SURVEY – HOOS, JR

**INSTRUCTIONS:** This survey asks for your view about your hips. This information will help us keep track of how you feel about your hips and how well you are able to do your usual activities.

Answer every question by ticking the appropriate box for each side, **only one box for each question**. If you are unsure about how to answer a question, please give the best answer you can.

## Pain

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

1. Going up or down stairs

| | | | | | |
|---|---|---|---|---|---|
| **Right**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |
| **Left**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |

2. Walking on an uneven surface

| | | | | | |
|---|---|---|---|---|---|
| **Right**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |
| **Left**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |

## Functions of daily living

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

3. Rising from sitting

| | | | | | |
|---|---|---|---|---|---|
| **Right**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |
| **Left**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |

4. Bending to floor/pick up an object

| | | | | | |
|---|---|---|---|---|---|
| **Right**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |
| **Left**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |

5. Lying in bed (turning over, maintaining hip position)

| | | | | | |
|---|---|---|---|---|---|
| **Right**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |
| **Left**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |

6. Sitting

| | | | | | |
|---|---|---|---|---|---|
| **Right**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |
| **Left**: | ☐ None | ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Extreme |

**Name**: _____

**Account**: _____ **Date**: _____

# AORI Clinical Hip Forms: Patient Satisfaction Questionnaire

Please answer the questions below by ticking the appropriate box for each side, **only one box for each question**. If you are unsure about how to answer a question, please give the best answer you can.

| **Left Hip** | **Right Hip** |
|---|---|
| ☐ Not replaced **(stop here)** | ☐ Not replaced **(stop here)** |
| Are you **satisfied** with your ***left*** hip replacement?<br>☐ YES ☐ NO | Are you **satisfied** with your ***right*** hip replacement?<br>☐ YES ☐ NO |
| Do you have **better function** in your hip since your ***left*** hip replacement?<br>☐ YES ☐ NO | Do you have **better function** in your hip since your ***right*** hip replacement?<br>☐ YES ☐ NO |
| Do you have **less pain** in your hip since your ***left*** hip replacement?<br>☐ YES ☐ NO | Do you have **less pain** in your hip since your ***right*** hip replacement?<br>☐ YES ☐ NO |

**Name**: _____

**Account**: _____ **Date**: _____

# PROMIS® Scale v1.2 – Global Health

Please respond to each question or statement by marking **one box per row**.

1. In general, would you say your health is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. In general, would you say your quality of life is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

3. In general, how would you rate your physical health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

4. In general, how would you rate your mental health, including your mood and your ability to think?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

5. In general, how would you rate your satisfaction with your social activities and relationships?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

6. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

7. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

☐ Completely ☐ Mostly ☐ Moderately ☐ A little ☐ Not at all

8. **In the past 7 days**, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

9. **In the past 7 days**, how would you rate your fatigue on average?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

10. **In the past 7 days**, how would you rate your pain on average?

| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| No pain | | | | | | | | | | Worst pain imaginable |