**PROBLEMS WITH YOUR HIP ?**

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| **Your Details** | | | | |
| **GP Practice:** | |  | **GP:** |  |
| **Your Name:** | |  | **Your Date of Birth:** |  |
| **Your Address:** | |  | **Your Contact Telephone Number:** |  |
| **Your NHS Number:** | |  | **Date You Completed This Questionnaire:** |  |
| **During the Past 4 weeks… Tick one box for each question** | | | | |
| 1 | How would you describe the pain you usually have from your hip?  None Very Mild Mild Moderate Severe    **(4) (3) (2) (1) (0)** | | | |
| 2 | Have you had any trouble with washing and drying yourself (all over) because of your hip?  No Trouble Very Little Moderate Extreme Impossible  At All Trouble Trouble Difficulty To Do    **(4) (3) (2) (1) (0)** | | | |
| 3 | Have you had any trouble getting in and out of a car or using public transport because of your hip? *(whichever you would normally use)*  No Trouble Very Little Moderate Extreme Impossible  At All Trouble Trouble Difficulty To Do    **(4) (3) (2) (1) (0)** | | | |
| 4 | For how long have you been able to walk before pain from your hip becomes **severe**? *(with or without a walking aid like a stick/frame)*  No Pain/ 16 to 30 5 to 15 Around the Not At All  More Than 30 Minutes Minutes House Only Pain Severe  Minutes When Walking    **(4) (3) (2) (1) (0)** | | | |
| 5 | After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your hip?  Not At All Slightly Moderately Very Unbearable  Painful Painful Painful Painful    **(4) (3) (2) (1) (0)**  ***Please Turn Over – More Questions Overleaf…*** | | | |
| 6 | Have you been limping when walking, because of your hip?  Rarely/ Sometimes Often, Not Most Of All Of  Never Or Just At Just At The Time The Time First First    **(4) (3) (2) (1) (0)** | | | |
| 7 | Have you had any sudden, severe pain (shooting, stabbing or spasms) from your affected hip?  No Only 1 or 2 Some Most Every  Days Days Days Days Day    **(4) (3) (2) (1) (0)** | | | |
| 8 | Have you been troubled by pain from your hip in bed at night?  No Only 1 or 2 Some Most Every  Nights Nights Nights Nights Night    **(4) (3) (2) (1) (0)** | | | |
| 9 | How much has pain from your hip interfered with your usual work (*including housework)*?  Not At A Little Moderately Greatly Totally  All Bit    **(4) (3) (2) (1) (0)** | | | |
| 10 | Have you been able to put on a pair of socks, stockings or tights?  Yes With Little With Moderate With Extreme No  Easily Difficulty Difficulty Difficulty Impossible    **(4) (3) (2) (1) (0)** | | | |
| 11 | **Could** you do the household shopping on your own?  Yes With Little With Moderate With Extreme No  Easily Difficulty Difficulty Difficulty Impossible    **(4) (3) (2) (1) (0)** | | | |
| 12 | **Could** you climb up one flight of stairs?  Yes With Little With Moderate With Extreme No  Easily Difficulty Difficulty Difficulty Impossible    **(4) (3) (2) (1) (0)** | | | |

Thank you for completing this questionnaire, please give this sheet to

the Physiotherapist or Reception/your GP at your practice

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| **For Practice Use Only** | |
| Calculated Oxford Hip Score For Patient Name: |  |