

HOOS HIP SURVEY



Today's date: ____/____/____ Date of birth: ____/____/____

Name: _____

INSTRUCTIONS: This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities. Answer every question by ticking the appropriate box, only one box for each question. If you are uncertain about how to answer a question, please give the best answer you can.

SYMPTOMS

These questions should be answered thinking of your hip symptoms and difficulties during the **last week**.

S1. Do you feel grinding, hear clicking or any other type of noise from your hip?

Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S2. Difficulties spreading legs wide apart

Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S3. Difficulties to stride out when walking

Never	Rarely	Sometimes	Often	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STIFFNESS

The following questions concern the amount of joint stiffness you have experienced during the **last week** in your hip. Stiffness is a sensation of restriction or slowness in the ease with which you move your hip joint.

S4. How severe is your hip joint stiffness after first wakening in the morning?

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

S5. How severe is your hip stiffness after sitting, lying or resting **later in the day**?

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAIN

P1. How often is your hip painful?

Never	Monthly	Weekly	Daily	Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

P2. Straightening your hip fully

None Mild Moderate Severe Extreme

P3. Bending your hip fully

None Mild Moderate Severe Extreme

P4. Walking on a flat surface

None Mild Moderate Severe Extreme

P5. Going up or down stairs

None Mild Moderate Severe Extreme

P6. At night while in bed

None Mild Moderate Severe Extreme

P7. Sitting or lying

None Mild Moderate Severe Extreme

P8. Standing upright

None Mild Moderate Severe Extreme

P9. Walking on a hard surface (asphalt, concrete, etc.)

None Mild Moderate Severe Extreme

P10. Walking on an uneven surface

None Mild Moderate Severe Extreme

FUNCTION, 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.

A1. Descending stairs

None Mild Moderate Severe Extreme

A2. Ascending stairs

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A3. Rising from sitting

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A4. Standing

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A5. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A6. Walking on flat surface

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A7. Getting in/out of car

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A8. Going shopping

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A9. Putting on socks/stockings

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A10. Rising from bed

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A11. Taking off socks/stockings

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A12. Lying in bed (turning over, maintaining hip position)

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A13. Getting in/out of bath

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A14. Sitting

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A15. Getting on/off toilet

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc)

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A17. Light domestic duties (cooking, dusting, etc)

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FUNCTION, SPORTS AND RECREATIONAL ACTIVITIES

The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your hip.

SP1. Squatting

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP2. Running

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP3. Twisting/pivoting on your injured hip

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SP4. Walking on uneven surface

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

QUALITY OF LIFE

Q1. How often are you aware of your hip problem?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Never | Monthly | Weekly | Daily | Always |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Q2. Have you modified your life style to avoid potentially damaging activities to your hip?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all | Mildly | Moderately | Severly | Totally |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Q3. How much are you troubled with lack of confidence in your hip?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all | Mildly | Moderately | Severly | Extremely |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Q4. In general, how much difficulty do you have with your hip?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| None | Mild | Moderate | Severe | Extreme |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

THANK YOU VERY MUCH FOR COMPLETING ALL THE QUESTIONS IN THIS QUESTIONNAIRE.

