

# Hip and Knee Questionnaire



ALTA ORTHOPAEDICS

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Area of problem:     Right    Left    Both ---    Hip    Knee

How severe is the problem?    mild    moderate    severe

Where does it hurt?     all over    front    back    inside    outside

When and how did the problem start? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

How long can you walk in minutes? \_\_\_\_\_

Does your hip or knee hurt at night?    No    Yes                      while sitting?    No    Yes

Are you able to reach your feet to put on shoes/socks?    No    Yes    with difficulty

Are you able to walk on stairs or steps?    No    Yes    Only using a hand rail  
 Only one step at a time

Does your hip/knee have any of the following?

- Bruising     Stiffness             Weakness             Swelling
- Catching     Popping             Clicking             Grinding
- Tingling     Numbness            Instability/Giving Way

Have you been seen for this problem before?    No    Yes   If Yes, by who? \_\_\_\_\_

Have you had any of the following tests?

X-ray    MRI     CT Scan     Bone scan     Nerve Conduction Test     Other \_\_\_\_\_

What treatments have you tried?

- none             rest             heat             ice             physical therapy
- cast             brace             injections     orthotics     acupuncture
- medication (list) \_\_\_\_\_     other: \_\_\_\_\_

Did anything help? \_\_\_\_\_

Please list any surgeries on your hip or knee:

Date:

\_\_\_\_\_

\_\_\_\_\_