



42533

TRAUMA - Hip Patient History

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Medical Record Number

Grid for Medical Record Number: 12 empty boxes

Date of Visit

Grid for Date of Visit: MM / DD / YYYY

First Name

Grid for First Name: 15 empty boxes

Middle

Grid for Middle: 1 empty box

Last Name

Grid for Last Name: 25 empty boxes

Suffix Sr. Jr. III IV M.D. PhD

Date of Birth

Grid for Date of Birth: MM / DD / YYYY (4 digit ex. 1922)

Gender

Female Male

Race

African American Asian Caucasian Hispanic Native American Other _____

Marital Status

Single Married Living with significant other Divorced Separated Widowed

Location of Problem

Right hip Left hip

If you are seeing us for more than one problem, which ONE is the worst?

Right hip Left hip

Please describe your current problem (If you are seeing the doctor for multiple problems, answer for the most severe)

- New Injury or problem (less than 6 weeks duration)
- Subacute problem (began slowly with no identifiable cause and progressively worsened)
- Chronic problem (problem has been present over time period of more than 3 months and never been restored to normal)
- Re-injury (you injured this same area before, received treatment, had no problems until this new injury occurred)

Date problem began (approximate if unsure)

Grid for Date problem began: MM / DD / YYYY

Date of re-injury

Grid for Date of re-injury: MM / DD / YYYY

Is your problem a result of an injury? Yes No

ANSWER THE QUESTIONS IN THIS BOX ONLY IF YOUR PROBLEM IS THE RESULT OF AN INJURY

If your problem is the result of an injury, where did it occur? (check one answer only)

Home Work Motor vehicle accident Exercise Sport Competition Other (specify) _____

What caused your injury?

- Fall Fighting
- Lifting Twisting
- Throwing Collision/Contact
- Reaching Other (specify) _____
- Pulling

Check any of the following that happened at the time of your injury

Felt pain Heard popping Had swelling Dislocation Fracture Other (specify) _____

Have you talked to a lawyer about today's problem? Yes No Court case pending? No Yes

Are you receiving or have you applied for workers compensation concerning your injury? Yes No

Case Manager's Name

Grid for Case Manager's Name: 25 empty boxes

Have you received previous treatment for your current problem? Yes No

If yes, please specify treatment type (**check all that apply**) and provide the **# of the procedures or weeks of physical therapy** you have had for the specific problem you are seeing the doctor for today

- ER Visit chiropractic
- oral medicine massage therapy
- physical therapy # of weeks
- surgical # of surgeries
- injections # of injections
- acupuncture
- other _____ (specify)

Please tell us your height and weight

Height

Grid for Height: ft inches

Weight

Grid for Weight: pounds



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·Please check any of the following conditions you have or have had in the past.
·If you are unsure, please ask a staff member to assist you in filling out this form.

You may check more than one condition.

Medical Condition History Check this box if you have **no** medical problems no medical problems

- Alcoholism
- Anemia
- Anxiety
- Asthma
- Arthritis - rheumatoid (verified with blood test)
- Arthritis - osteo, degenerative
- Blood Clot Year
- Blood Transfusion Year
- Bowel disease
- Cancer (specify) _____
- Cardiac Arrhythmia (Abnormal heart rate)
- Congestive Heart Failure
- Coronary Artery Disease (Angina)
- Cerebrovascular Disease (Stroke)
- COPD (Chronic Obstructive Pulmonary Disease)
- Diabetes
- Depression
- Fibromyalgia
- GERD
- Gout
- Heart Attack Year
- Hypertension (High Blood Pressure)
- Hypercholesterolemia (Elevated Cholesterol)
- Hypothyroidism
- Kidney Disease
- Liver Disorder - Cirrhosis
- Liver Disorder - Hepatitis
- Lung Disease
- Osteomyelitis
- Parkinson's
- Ulcer Disease
- Other (specify all other) _____

Surgery/ Procedures These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

Have you ever had surgery? Yes No

Ear, Nose, Throat Surgeries

- Deviated Septum -----
- Sinus Repair -----
- Tonsillectomy -----
- Tracheostomy -----
- Vocal Cord Surgery -----

Gastrointestinal Surgeries

- Appendectomy -----
- Cholecystectomy (Gallbladder removed) -----
- Colon Resection -----
- Exploratory Laparoscopy -----
- Hernia -----
- Femoral Incisional Inguinal Umbilical
- Liver Resection -----
- Small Bowel Obstruction Repair -----
- Splenectomy -----

Gynecologic Surgeries

- Hysterectomy -----
- Oophorectomy -----
- Ruptured ectopic -----
- Laprascopy -----
- C-Section -----

Urologic Surgeries

- Bladder Suspension -----
- Bladder Removed -----
- Lithotripsy (Stone Machine) -----
- Prostatectomy (Prostate Removed) -----
- Vasectomy -----

General Surgeries

- Breast Biopsy .. Right Left Bilateral ..
- Mastectomy -- Right Left Bilateral ..
- Thyroid Surgery -----
- Whipple -----

Heart (Cardiac) Surgeries

- CABG_ # arteries 1 2 3 4 4+ -----
- Valve -- Aortic Mitral Tricuspid -----
- Angioplasty -----
- Defibrillator -----
- Pace Maker -----

Vascular Surgeries

- Bypass Graft - Legs -----
- Vascular Access -----
- AAA -----
- Thoracic Aneurysm -----

Thoracic Surgeries

- Chest Tube -----
- Pulmonary -----
- Pectus -----

Neurosurgeries

- Brain Tumor ----- Malignant Benign ..
- Brain Aneurysm -----
- Chiari Decompression -----
- Spinal Cord Tumor_ Malignant Benign ..
- Epidural Injection -----
- Abscess -----
- Stent -----



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Orthopaedic Surgery/ Procedures

Please check any procedures you have had and give the year.

Most Recent Year

Previous Surgery Year

(if same surgery performed more than once)

Broken Bones/Fracture Repair Surgeries

<input type="checkbox"/> Fracture Repair - Finger	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Fracture Repair - Hand	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Fracture Repair - Wrist	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Fracture Repair - Arm	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Fracture Repair - Elbow	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Fracture Repair - Shoulder	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Fracture Repair - Hip/Pelvis	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Fracture Repair - Femur	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Fracture Repair - Knee	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Fracture Repair - Lower Leg	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Fracture Repair - Ankle/Foot	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Ankle/Foot Surgeries

<input type="checkbox"/> Ankle Arthroscopy	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Ankle Fusion	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Tendon Surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Toe Surgery specify _____	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Elbow, Wrist, Hand Surgeries

<input type="checkbox"/> Biceps Repair	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Carpal Tunnel Surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Elbow Arthroscopy	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Elbow Ligament Reconstruction	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Elbow Replacement	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Hand Tendon Repair	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Nail Bed Surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Tennis Elbow Surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Trigger Finger Surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Wrist Ligament Reconstruction	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Knee Surgeries

<input type="checkbox"/> Knee Arthroscopy	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Cartilage surgery/meniscus surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Knee replacement	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Ligament reconstruction - ACL	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Ligament reconstruction - other	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Hip Surgeries

<input type="checkbox"/> Hip replacement	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> AVN Surgery <input type="radio"/> Core Decompression <input type="radio"/> Fibular Graft	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Shoulder Surgeries

<input type="checkbox"/> Shoulder Arthroscopy	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Rotator cuff surgery	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Shoulder replacement	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Shoulder stabilization	-----	<input type="radio"/> Right	<input type="radio"/> Left	<input type="radio"/> Bilateral	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Spine Surgeries

<input type="checkbox"/> Laminectomy	-----	<input type="checkbox"/> Cervical	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Thoracic	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Anterior Fusion	-----	<input type="checkbox"/> Cervical	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Thoracic	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Posterior Fusion	-----	<input type="checkbox"/> Cervical	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Thoracic	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Posterior Discectomy	-----	<input type="checkbox"/> Cervical	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Thoracic	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-----	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other (List all other surgeries) _____



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Hand Dominance: Right Left Use both equally

Harris Hip

Please answer the following questions to the best of your ability. Select the one answer that best describes your situation. Check **ONLY ONE** answer for each question. If you have any questions, the nurse will be happy to assist you.

How would you rate your hip today as a percentage of normal (0% - 100%, with 100% being normal)? %

A. Hip Evaluation

1. Pain **Please describe your pain** none slight mild moderate marked totally disabled

B. Function

1. Limp

Please describe your limp

- I have no limp
- I have a slight limp
- I have a moderate limp
- I have a severe limp
- I am unable to walk

2. Support

Please describe the assistance you require

- none
- I use a cane for long walks
- I use a cane full time
- I use one crutch
- I use two canes
- I use two crutches/walker
- I am unable to walk

3. Distance Walked

Please describe the distance you are able to walk

- I am not limited in the distance I can walk
- I am limited in the distance I can walk to 6 blocks
- I am limited in the distance I can walk to 2-3 blocks
- I am limited to walking only indoors
- I am limited to walking to the bed and chair

C. Activities

1. Stairs

Please describe your ability to climb stairs

- I am able to climb stairs normally
- I am able to climb stairs normally with the use of a banister
- I climb stairs with any method
- I am unable to climb stairs

2. Socks/Tie Shoes

Please describe your ability to put on shoes and socks

- I am able to put on shoes/socks with ease
- I am able to put on shoes/socks with difficulty
- I am unable to put on shoes/socks

3. Sitting

Please describe your ability to sit

- I can sit in any chair up to 1 hour
- I can sit in a high chair for 1/2 hour
- I am unable to sit in any chair for 1/2 hour

4. Public Transportation

Please describe your ability to use public transportation

- I am able to enter public transportation
- I am unable to enter public transportation

Have you had hip replacement surgery? No Yes

If you have had hip replacement surgery please answer the next 2 questions

Overall, what is your level of satisfaction with Hip replacement surgery?

- Extremely satisfied
- Very satisfied
- Moderately satisfied
- Slightly satisfied
- Not at all satisfied

If you could, would you choose again to have this surgery performed on your Hip? No Yes



These questions are about how much difficulty you may be having this week with your daily activities because of your injury or arthritis.

1. How difficult is it for you to get in or out of a low chair?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
2. How difficult is it for you to open medicine bottles or jars?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
3. How difficult is it for you to shop for groceries or other things?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
4. How difficult is it for you to climb stairs?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
5. How difficult is it for you to make a tight fist?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
6. How difficult is it for you to get in or out of the bathtub or shower?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
7. How difficult is it for you to get comfortable to sleep?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
8. How difficult is it for you to bend or kneel down?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
9. How difficult is it for you to use buttons, snaps, hooks, or zippers?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
10. How difficult is it for you to cut your own fingernails?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
11. How difficult is it for you to dress yourself?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
12. How difficult is it for you to walk?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
13. How difficult is it for you to get moving after you have been sitting or lying down?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
14. How difficult is it for you to go out by yourself?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
15. How difficult is it for you to drive?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
16. How difficult is it for you to clean yourself after going to the bathroom?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
17. How difficult is it for you to turn knobs or levers, for example, open doors, roll down car windows?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do
18. How difficult is it for you to write or type?
 Not at all difficult A little difficult Moderately difficult Very difficult Unable to do



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19. How difficult is it for you to pivot?

- Not at all difficult A little difficult Moderately difficult Very difficult Unable to do

20. How difficult is it for you to do your usual physical recreational activities, such as bicycling, jogging, or walking?

- Not at all difficult A little difficult Moderately difficult Very difficult Unable to do

21. How difficult is it for you to do your usual leisure activities, such as hobbies, crafts, gardening, card playing, going out with friends?

- Not at all difficult A little difficult Moderately difficult Very difficult Unable to do

22. How much difficulty are you having with sexual activity?

- Not at all difficult A little difficult Moderately difficult Very difficult Unable to do

23. How difficult is it for you to do light housework or yardwork, such as dusting, washing dishes, or watering plants?

- Not at all difficult A little difficult Moderately difficult Very difficult Unable to do

24. How difficult is it for you to do heavy housework or yardwork, such as washing floors, vacuuming, or mowing lawns?

- Not at all difficult A little difficult Moderately difficult Very difficult Unable to do

25. How difficult is it for you to do your usual work, such as paid job, housework, volunteer activities?

- Not at all difficult A little difficult Moderately difficult Very difficult Unable to do

These next questions ask how often you are experiencing problems this week, because of your injury or arthritis.

26. How often do you walk with a limp?

- None of the time A little of the time Some of the time Most of the time All of the time

27. How often do you avoid using your painful limb(s) or back?

- None of the time A little of the time Some of the time Most of the time All of the time

28. How often does your leg lock or give-way?

- None of the time A little of the time Some of the time Most of the time All of the time

29. How often do you have problems with concentration?

- None of the time A little of the time Some of the time Most of the time All of the time

30. How often does doing too much in one day affect what you do the next day?

- None of the time A little of the time Some of the time Most of the time All of the time

31. How often do you act irritable toward those around you, for example, snap at people, give sharp answers, criticize easily?

- None of the time A little of the time Some of the time Most of the time All of the time

32. How often are you tired?

- None of the time A little of the time Some of the time Most of the time All of the time

33. How often do you feel disabled?

- None of the time A little of the time Some of the time Most of the time All of the time

34. How often do you feel angry or frustrated that you have this injury or arthritis?

- None of the time A little of the time Some of the time Most of the time All of the time



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These questions are about how much you are bothered by problems you are having this week, due to your injury or arthritis.

How much are you bothered by...

	<u>Not at all bothered</u>	<u>A little bothered</u>	<u>Moderately bothered</u>	<u>Very bothered</u>	<u>Extremely bothered</u>
35. Problems using your hands, arms or legs	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
36. Problems using your back	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
37. Problems doing work around your home	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
38. Problems with bathing, dressing, toileting or other personal care	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
39. Problems with sleep and rest	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
40. Problems with leisure or recreational activities	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
41. Problems with your friends, family or other important people in your life	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
42. Problems with thinking, concentrating or remembering	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
43. Problems adjusting or coping with your injury or arthritis	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
44. Problems doing your usual work	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
45. Problems with feeling dependent on others	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
46. Problems with stiffness and pain	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

PLEASE RETURN THIS COMPLETED PACKET TO THE FRONT DESK NOW