HOOS HIP SURVEY

Today's Date: ____/____/____ Date of Birth: ____/____/____

Name: _____

Please rate your pain level with activity:

0 1 2 3 4 5 6 7 8 9 10

No Pain Very Severe Pain

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

S2. Difficulties spreading legs wide apart

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

S3. Difficulties to stride out when walking

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

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

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

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

Pain

P1. How often is your hip painful?

○ Never ○ Monthly ○ Weekly ○ Daily ○ Always

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

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

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

A3. Rising from sitting

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A4. Standing

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

A5. Bending to floor/pick up an object

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A6. Walking on flat surface

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A7. Getting in/out of car

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A8. Going shopping

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A9. Putting on socks/stockings

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A10. Rising from bed

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A11. Taking off socks/stockings

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

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

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A13. Getting in/out of bath

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A14. Sitting

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

A15. Getting on/off toilet

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

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

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

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

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

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

SP2. Running

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

SP3. Twisting/pivoting on loaded leg

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

SP4. Walking on uneven surface

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

Quality of Life

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

○ Never ○ Monthly ○ Weekly ○ Daily ○ Constantly

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

○ Not at all ○ Mildly ○ Moderately ○ Severely ○ Totally

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

○ Not at all ○ Mildly ○ Moderately ○ Severely ○ Extremely

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

○ None ○ Mild ○ Moderate ○ Severe ○ Extreme

Thank you very much for completing all the questions in this questionnaire.