Hip Joint Replacement Follow Up Form - Scott D. Anseth, MD

STICKER FIELD

If there is **not any sticker available** please write the required data below:

Patient First Name:

Patient Last Name:

Medical Record Number:

Date of Birth:

What is patient's height?

☐ **Feet** ☐☐ **Inches**

What is patient's weight?

☐☐☐ **Pounds**

Date of your Hip Surgery (MM/DD/YYYY)

☐☐/☐☐/☐☐☐☐

Today's Date (MM/DD/YYYY)

☐☐/☐☐/☐☐☐☐

Email: **(Please provide your email address below for easy follow up and progress feedback)**

Site of your Hip Surgery:

- ○ **Right**
- ○ **Left**
- ○ **Bilateral**
- ○ **N/A**

Do you currently smoke cigarettes or use any other tobacco products ? (Mark one response.)

- ○ **Yes**
- ○ **No, I quit smoking or using any other tobacco products less than 6 months ago.**
- ○ **No, I quit smoking or using any other tobacco products more than 6 months ago.**
- ○ **No, I have never smoked or used any other tobacco products .**

Complications	**YES**	**NO**
Is there any joint infection reported as a result of your hip surgery?	○	○
Do you have blood clot in your legs (DVT) as a result of your hip surgery?	○	○
Do you have blood clot traveling to your lungs (PE) as a result of your hip surgery?	○	○

EQ-5D-5L™

Under each heading, please fill ONE circle that best describes your health TODAY.

Mobility

- ○ I have no problems walking
- ○ I have slight problems walking
- ○ I have moderate problems walking
- ○ I have severe problems walking
- ○ I am unable to walk

Self-Care

- ○ I have no problems washing or dressing myself
- ○ I have slight problems washing or dressing myself
- ○ I have moderate problems washing or dressing myself
- ○ I have severe problems washing or dressing myself
- ○ I am unable to wash or dress myself

Usual Activities *(e.g. work, study, housework, family or leisure activities)*

- ○ I have no problems doing my usual activities
- ○ I have slight problems doing my usual activities
- ○ I have moderate problems doing my usual activities
- ○ I have severe problems doing my usual activities
- ○ I am unable to do my usual activities

Pain/Discomfort

- ○ I have no pain or discomfort
- ○ I have slight pain or discomfort
- ○ I have moderate pain or discomfort
- ○ I have severe pain or discomfort
- ○ I have extreme pain or discomfort

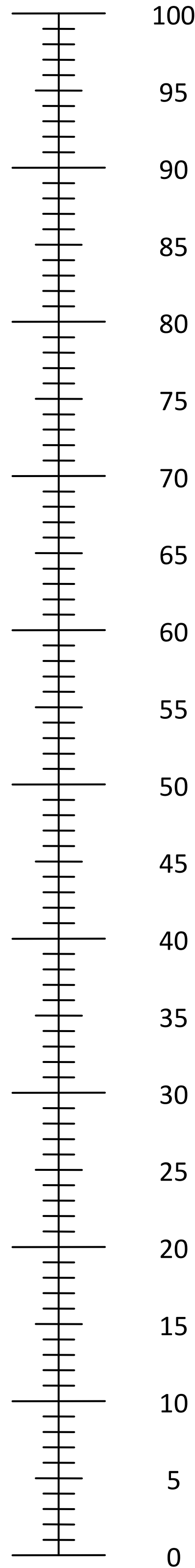
Anxiety/Depression

- ○ I am not anxious or depressed
- ○ I am slightly anxious or depressed
- ○ I am moderately anxious or depressed
- ○ I am severely anxious or depressed
- ○ I am extremely anxious or depressed

EQ-5D-5L™ (continues)

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Select a number on the scale to indicate how your health is TODAY.
- Now, please write the number you selected on the scale in the box ABOVE.

The best health you can imagine



The worst health you can imagine

Your Health Today (0-100)

Please enter your health state score above

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OXFORD HIP SCORE

The purpose of the Oxford Hip Score is to help assess the impact of your hip pain has had on your daily life in the PAST FOUR WEEKS. The following questions must ALL be answered on your experiences over the PAST FOUR WEEKS.

1. During the past four weeks; How would you describe the pain you usually had from your hip?

○ None
○ Very Mild
○ Mild
○ Moderate
○ Severe

2. During the past four weeks; Have you had any trouble with washing and drying yourself (all over) because of your hip?

○ No trouble at all
○ Very little trouble
○ Moderate trouble
○ Extreme difficulty
○ Impossible to do

3. During the past four weeks; Have you had any trouble getting in and out of a car or using public transport because of your hip? (whichever you tend to use)

○ No trouble at all
○ Very little trouble
○ Moderate trouble
○ Extreme difficulty
○ Impossible to do

4. During the past four weeks; Have you been able to put on a pair of socks, stockings or tights?

○ Yes, Easily
○ With little difficulty
○ With moderate difficulty
○ With extreme difficulty
○ No, Impossible

5. <u>During the past four weeks</u>; Could you do the household shopping <u>on your own</u>?

- ○ Yes, easily
- ○ With little difficulty
- ○ With moderate difficulty
- ○ With extreme difficulty
- ○ No, impossible

6. <u>During the past four weeks</u>; For how long have you been able to walk before <u>pain from your hip</u> becomes severe (with or without a walking aid)?

- ○ No pain/ more than 30 minutes
- ○ 16-30 minutes
- ○ 5-15 minutes
- ○ Around the house only
- ○ Not at all – pain severe when walking

7. <u>During the past four weeks</u>; Have you been able to climb a flight of stairs?

- ○ Yes, easily
- ○ With little difficulty
- ○ With moderate difficulty
- ○ With extreme difficulty
- ○ No, impossible

8. <u>During the past four weeks</u>; After a meal (sat a table), how painful has it been for you to stand up from a chair <u>because of your hip</u>?

- ○ Not at all painful
- ○ Slightly painful
- ○ Moderately painful
- ○ Very painful
- ○ Unbearable

9. <u>During the past four weeks</u>; have you been limping when walking <u>because of your hip</u>?

- ○ Rarely/never
- ○ Sometimes, or just at first
- ○ Often, not just at first
- ○ Most of the time
- ○ All of the time

10. <u>During the past four weeks</u>; have you had any sudden, severe pain – 'shooting', 'stabbing' or 'spasms' – <u>from the affected hip</u>?

- ○ No days
- ○ Only 1 or 2 days
- ○ Some days
- ○ Most days
- ○ Every day

11. <u>During the past four weeks</u>; how much has <u>pain from your hip</u> interfered with your usual work? (including housework)

- ○ Not at all
- ○ A little bit
- ○ Moderately
- ○ Greatly
- ○ Totally

12. <u>During the past four weeks</u>; have you been troubled by <u>pain from your hip</u> in bed at night?

- ○ No nights
- ○ Only 1 or 2 nights
- ○ Some nights
- ○ Most nights
- ○ Every night

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LOWER EXTREMITY ACTIVITY SCALE (LEAS)

FIRST read through each description given below.
Then Pick ONLY ONE description that best describes your regular daily activity TODAY.
PLEASE SELECT ONLY ONE CHOICE.

Today	Activity Levels
○	I am confined to bed all day.
○	I am confined to bed most of the day except for minimal transfer activities (going to the bathroom, etc.)
○	I am either in bed or sitting in a chair most of the day.
○	I sit most of the day, except for minimal transfer activities, no walking or standing.
○	I sit most of the day, but I stand occasionally and walk a minimal amount in my house. (I may rarely leave the house for an appointment and may require the use of a wheelchair or scooter for transportation.)
○	I walk around my house to a moderate degree but I don't leave the house on a regular basis. I may leave the house occasionally for an appointment.
○	I walk around my house and go outside at will, walking one or two blocks at a time.
○	I walk around my house, go outside at will and walk several blocks at a time without any assistance (weather permitting).
○	I am up and about at will in my house and can go out and walk as much as I would like with no restrictions (weather permitting).
○	I am up and about at will in my house and outside. I also work outside the house in a minimally active job.
○	I am up and about at will in my house and outside. I also work outside the house in a moderately active job.
○	I am up and about at will in my house and outside. I also work outside the house in an extremely active job.
○	I am up and about at will in my house and outside. I also participate in relaxed physical activity such as jogging, dancing, cycling, swimming occasionally (2-3 times per month.
○	I am up and about at will in my house and outside. I also participate in relaxed physical activity such as jogging, dancing, cycling, swimming 2-3 times per week.
○	I am up and about at will in my house and outside. I also participate in relaxed physical activity such as jogging, dancing, cycling, swimming daily.
○	I am up and about at will in my house and outside. I also participate in vigorous physical activity such as competitive level sports occasionally (2-3 times per month.
○	I am up and about at will in my house and outside. I also participate in vigorous physical activity such as competitive level sports 2-3 times per week.
○	I am up and about at will in my house and outside. I also participate in vigorous physical activity such as competitive level sports daily.

VISUAL ANALOG PAIN SCALE (VAS) - HIP PAIN

Indicate the severity of your hip pain level over PAST ONE WEEK by filling in any one circle that most applies to you from 0 "No Pain" to 10 "Worst Possible Pain".

RIGHT Hip Pain - My pain level over PAST ONE WEEK with walking & activity:

○ ○

"0"
No Pain

"10"
Worst Possible Pain

LEFT Hip Pain - My pain level over PAST ONE WEEK with walking & activity:

○ ○

"0"
No Pain

"10"
Worst Possible Pain