

**Bay Area Surgical Specialists
Benjamin Busfield M.D., F.A.A.O.S.**

Orthopedic Surgery and Sports Medicine

HIP COMPLAINT:

Name: _____ Date: _____

Profession: _____

Which hip hurts: Left Right Both

How long has the hip hurt? _____ Months or _____ Years

Any past hip injuries? Yes No

Any past hip surgeries? Yes No If yes, what year and what surgery was done?

Pain (rate from 0-10, 10 is worst, 0 is no pain) 0 1 2 3 4 5 6 7 8 9 10

Describe pain: Burning/tingling Deep ache Stabbing Other: _____

Pain location: Groin Buttock Side of hip Shooting down leg into foot

Associated symptoms: Tingling in foot Clicking Stiffness

Any recent treatment? Anti-inflammatory meds Yes No Physical Therapy Yes No

Chiropractor Yes No Ice Yes No Injections Yes No

What makes pain better? Rest from activity Yes No Pain medications Yes No

Physical Therapy Yes No Ice Yes No

What makes pain worse? Walking Yes No Running Yes No Lifting Yes No

Work Yes No Sleeping on side Yes No

Is your walking limited? Yes No

If yes, how many city blocks can you walk _____

Do you use any aides?: Cane Yes No Walker Yes No Wheelchair Yes No

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