LEXINGTON MEDICAL CENTER

HOOS, JR. HIP SURVEY

Hip Disfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS, JR.), English version 1.0

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 unsure about how to answer a question, please give the best answer you can.

Pain

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

1. Going up or down stairs

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

2. 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.

3. Rising from sitting

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

4. Bending to floor/pick up an object

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

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

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

6. Sitting

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

FORMS ARE FOR POST-SURGICAL TOTAL HIP REPLACEMENT ORTHOPAEDIC OFFICE VISITS.

PATIENT'S NAME:_____

M#:_____

OR STICKER

TODAY'S DATE:_____

DATE OF SURGERY:_____

FOLLOW UP VISIT:_____