

New patients and patients arriving for new problems need to arrive 15 minutes before their scheduled appointment time. If you are not early the appointment will be rescheduled.

**Dr. Messamore
New Patient Hip Questionnaire**

Patient Name: _____

MRN: _____ (for office use)

Patient Information

Is someone with you at your appointment today?

Name: _____ Relationship to Patient: _____

Who recommended you to see Dr. Messamore? _____

Chief Complaints (Circle all that apply):

Which hip is involved? Right / Left / Both Which is worse: Right / Left / Equal

Pain / Limited Motion / Weakness / Popping or Catching / Numbness

How long have you had this problem? _____

Did you have an injury? Yes / No If so, when? _____

How did the injury occur? _____

Any other injuries? _____

Symptoms Description: (Circle all that apply)

Pain Is your pain getting: Better / Worse / Same

Where is most of your pain? Groin / Buttocks / Outer Side (lateral) / Can't Tell

Intensity: (0=no pain, 10=worst possible pain): At its Best____ At its Worst____

Character: sharp & stabbing / dull ache / burning / throbbing / other: _____

Duration: constant / intermittent / only with activity / only at night
while sitting / while walking / other: _____

Limited Motion: What limits your motion? pain / strength loss / mechanical block (circle only one)

Work History:

Are you working? Employed / Unemployed / Full-time student / Retired

If NO, are you on disability? NO YES

IF YES, what medical condition causes your disability? _____

Employer: _____

Job Title: _____

Job Requirements: Heavy lifting / Manual labor / Stairs / Kneeling or Squatting / Desk Work

Exacerbating Activity (activities that worsen the symptoms, please circle):

Sitting for long periods / Squatting / Walking / Running / Twisting / Sports Activity

Other: (describe) _____

Relieving Activity (activities that improve the symptoms, please circle):

Heat / Ice / Massage / Avoiding Activities / Brace / Medication

Other: (describe) _____

Does the hip affect sleep? NO / YES

If yes, (circle the following): prevents getting to sleep / awakens at night/

Frequency: _____ times a week

Numbness: Do you get any numbness or tingling? YES / NO

When and where: _____

Activities and Hobbies:

Sports: (please list) _____

Other: (please list) _____

Does your complaint today affect these activities? YES / NO

Previous Tests

X-rays: NO / YES Date? _____ Where? _____

MRI: NO / YES Date? _____ Where? _____

Previous Treatment

Medication (including non prescription): NO / YES Name: _____ Helpful? NO / YES
Name: _____ Helpful? NO / YES
Name: _____ Helpful? NO / YES

Occupational/Physical Therapy NO / YES Where: _____ Helpful? NO / YES
Length of Time: _____

Chiropractic/Acupuncture NO / YES Where: _____ Helpful? NO / YES

Injection NO / YES Date: _____ By: _____ Helpful? NO / YES
Date: _____ By: _____ Helpful? NO / YES
Date: _____ By: _____ Helpful? NO / YES

Surgery NO / YES Date: _____ By: _____ Helpful? NO / YES
Date: _____ By: _____ Helpful? NO / YES
Date: _____ By: _____ Helpful? NO / YES

Other Current Orthopaedic Conditions

Neck	NO / YES	Who is providing treatment?	_____
Shoulder	NO / YES	Who is providing treatment?	_____
Wrist/Hand	NO / YES	Who is providing treatment?	_____
Back	NO / YES	Who is providing treatment?	_____
Hip	NO / YES	Who is providing treatment?	_____
Knee	NO / YES	Who is providing treatment?	_____
Ankle/Foot	NO / YES	Who is providing treatment?	_____

How would you rate your affected hip today as a percentage of normal? _____

How would you rate your opposite side today as a percentage of normal? _____
(0% to 100% scale with 100% being normal)

Thank you for choosing Dr. Messamore for your orthopaedic treatment. Please return this form at your appointment.

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