Total Hip Arthroplasty – Patient Assessment and Progress Sheet

Patient Sticker

Thank you for taking the time to answer these questions which should only take a few minutes. The answers you give are very useful as they will help us assess your progress following your surgery. If you have any difficulties with the questions please feel free to ask a member of staff for help.

Once you have filled in the form please hand it to the nurse or doctor in clinic and they will file it in your notes or **send to us by post**

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Date Today			
Your Age			
Your Occupation			
Side of symptoms (left or right)			
If you smoke, how many a day?			
Your Weight		BMI	
Your Height		ASA	

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Oxford Hip Score

Please answer the following 12 multiple choice questions.

During the past 4 weeks.....

1. How would you describe the pain you usually have in your hip?
None
Very mild
Mild
Moderate
Severe

2. Have you been troubled by pain from your hip in bed at night?
No nights
Only 1 or 2 nights
Some nights
Most nights
Every night

3. Have you had any sudden, severe pain (shooting, stabbing, or spasms) from your affected hip?
No days
Only 1 or 2 days
Some days
Most days
Every day

4. Have you been limping when walking because of your hip?
Rarely/never
Sometimes or just at first
Often, not just at first
Most of the time
All of the time

5. For how long have you been able to walk before the pain in your hip becomes severe (with or without a walking aid)?
No pain for 30 minutes or more
16 to 30 minutes

7. 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

8. After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your hip?
Not at all painful
Slightly painful
Moderately painful
Very painful
Unbearable

9. Have you had any trouble getting in and out of a car or using public transportation because of your hip?
No trouble at all
Very little trouble
Moderate trouble
Extreme difficulty
Impossible to do

10. 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

11. Could you do the household shopping on your own?
Yes, easily
With little difficulty

5 to 15 minutes	With moderate difficulty
Around the house only	With extreme difficulty
Not at all	No, impossible

6. Have you been able to climb a flight of stairs?	12. How much has pain from your hip interfered with your usual work, including housework?
Yes, easily	Not at all
With little difficulty	A little bit
With moderate difficulty	Moderately
With extreme difficulty	Greatly
No, impossible	Totally

Oxford Hip Score + Total
(Maximum 60, Minimum 12)

SF-12® Patient Questionnaire

Answer every question by placing a check mark on the line in front of the appropriate answer. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:
_____ Excellent (1)
_____ Very Good (2)
_____ Good (3)
_____ Fair (4)
_____ Poor (5)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving a table, bowling, playing golf, etc…:
_____ Yes, Limited A Lot (1)
_____ Yes, Limited A Little (2)
_____ No, Not Limited At All (3)

3. Climbing SEVERAL flights of stairs:
_____ Yes, Limited A Lot (1)
_____ Yes, Limited A Little (2)
_____ No, Not Limited At All (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like:
_____ Yes (1)
_____ No (2)

5. Were limited in the KIND of work or other activities:
_____ Yes (1)
_____ No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like:
_____ Yes (1)
_____ No (2)

7. Didn’t do work or other activities as CAREFULLY as usual:
_____ Yes (1)
_____ No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?
_____ Not At All (1)
_____ A Little Bit (2)
_____ Moderately (3)
_____ Quite A Bit (4)
_____ Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

10. Did you have a lot of energy?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

11. Have you felt downhearted and blue?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

12. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)