Hip Osteoarthritis Patient Charts

# Chart 1

Patient Name: Linda Thomas

Age/Sex: 58-year-old female

MRN: HR0001

Visit Date: 2025-06-18

Chief Complaint: Anterior thigh pain associated with hip range of motion or weight bearing

## History of Present Illness (HPI):

This is a 65-year-old female who has been struggling with her hip for the past 40 weeks, maybe longer if she is being honest, though she says it has gotten worse in the last couple of months. Linda Thomas describes a deep, aching pain in the groin, sometimes radiating toward the thigh, and it tends to tighten up if she sits too long. She says that if she sits to watch TV for a half hour, when she stands, the first dozen steps feel stiff until the hip loosens. Putting on socks or shoes has become difficult, sometimes needing help, which frustrates her independence. Conservative measures have included Tylenol (helpful briefly), meloxicam (takes the edge off), tramadol at night (causing grogginess), six weeks of PT (gained strength but pain persisted), cane use at times, and heat packs for temporary relief. Corticosteroid injection 23 weeks ago with about 44% relief for 6 weeks. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 6/10, up to 8/10 on bad days. Walking tolerance is about 300 feet before stopping. She has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

Smoking, Blood clot, Hyperlipidemia, Diabetes

## Past Surgical History:

Appendectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 34.3. Antalgic gait. Hip ROM limited: flexion 93°, IR 8°, ER 23°. Leg length discrepancy 1.5 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Diabetes—coordinate with PCP to optimize HbA1c <8%. Return in 3 weeks for reassessment.

# Chart 2

Patient Name: William Anderson

Age/Sex: 78-year-old male

MRN: HR0002

Visit Date: 2025-08-28

Chief Complaint: Catching or locking in groin

## History of Present Illness (HPI):

Anderson describes a deep, aching pain in the groin, sometimes radiating toward the thigh, and it tends to tighten up if he sits too long. He says that if he sits on the floor to play with his grandchildren or meditate. Putting on socks or shoes has become difficult, as well as feeding his dog, who is required to be hand-fed. No prior hip injections. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 6/10, up to 8/10 on bad days. Walking tolerance is about 300 feet before stopping..

## Past Medical History:

Obstructive sleep apnea, Hypertension, Diabetes, GERD

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.1 ppd × 31 yrs. Occasional marijuana use.

## Exam:

BMI 38.3. Antalgic gait. Hip ROM limited: flexion 88°, IR 4°, ER 21°. Leg length discrepancy 1.4 cm. Pain with a log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

Appropriate candidate for total hip arthroplasty; proceed with pre-op planning.

Will is nervous about surgery understandably due to his diabetes—coordinate with PCP to make him feel more confident. Also he is an active smoker so will require drug testing and quitting smoking prior to surgery..

# Chart 3

Patient Name: Elizabeth Davis

Age/Sex: 63-year-old female

MRN: HR0003

Visit Date: 2025-07-05

Chief Complaint: Pain radiating from groin to the level of the knee

## History of Present Illness (HPI):

This is a 74-year-old female who has been struggling with her hip for the past 3 years. She says she feels pain when practicing her daily Zumba routines, as well as planting her tomatoes and cleaning up her house. Conservative measures have included Tylenol (helpful briefly), meloxicam (takes the edge off), six weeks of PT (gained strength but pain persisted), cane use at times, and heat packs for temporary relief. Corticosteroid injection 19 weeks ago with about 78% relief for 6 weeks.

Past Medical History:

Blood clot, Hypertension

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 46.1. Antalgic gait. Hip ROM limited: flexion 93°, IR 3°, ER 25°. Leg length discrepancy 1.3 cm. Pain with a log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. She will return in 3 weeks for reassessment because she needs to lower her BMI before surgery.

# Chart 4

Patient Name: David Miller

Age/Sex: 85-year-old male

MRN: HR0004

Visit Date: 2025-06-11

Chief Complaint: Anterior thigh pain associated with hip range of motion or weight bearing

## History of Present Illness (HPI):

This is a 73-year-old male who has been struggling with his hip for the last 2-5 years, but now it's worse. David Miller describes a deep, aching pain in the groin and it tends to tighten up if he sits too long. He says that if he sits to watch the sunset for around 23 minutes, when he stands, the first dozen steps feel stiff like he is a penguin waddling until the hip loosen. Conservative measures have included Tylenol (unhelpful), meloxicam (takes the edge off), tramadol at night (causing grogginess), six weeks of PT (gained strength but pain persisted), cane use at times, and heat packs for temporary relief. No prior hip injections.

Past Medical History:

Diabetes, Hyperlipidemia

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 35.6. Antalgic gait. Hip ROM limited: flexion 87°, IR 3°, ER 15°. Leg length discrepancy 1.9 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. However before we proceed since David is diabetic we must work closely with his PCP to make sure the surgery will be safe for him.

# Chart 5

Patient Name: Mary Anderson

Age/Sex: 55-year-old female

MRN: HR0005

Visit Date: 2025-08-23

Chief Complaint: Hip or groin pain

## History of Present Illness (HPI):

This is a 74-year-old female who has been struggling with her hip for the past 77 weeks, maybe longer if she is being honest, though she says it has gotten worse in the last couple of months. Mary Anderson describes sharp pain sometimes radiating toward the thigh, and it tends to get worse and feel like he’s stuck in her place if she sits too long. Pain currently 6/10, up to 8/10 on bad days. Walking tolerance is about 500 feet before stopping. She has tried swimming instead of walking, but feels overall things are slowly getting worse. Mary states she does not enjoy swimming and it is not a realistic form of transportation in daily life so this is not a solution for her. She wants to travel and see the world, so she needs a functional hip.

## Past Medical History:

Obstructive sleep apnea, Blood clot, GERD, Hyperlipidemia

## Past Surgical History:

Appendectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 0.3 ppd × 35 yrs. Occasional marijuana use.

## Exam:

BMI 30.7. Antalgic gait. Hip ROM limited: flexion 89°, IR 5°, ER 16°. Leg length discrepancy 1.6 cm. Pain with a log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; However she is nervous for surgery due to her actively smoking and does not know if she will be able to quit. She will need support for this transition in her life.

# Chart 6

Patient Name: Maria Jones

Age/Sex: 77-year-old female

MRN: HR0006

Visit Date: 2025-06-14

Chief Complaint: Limping and pain

## History of Present Illness (HPI):

This is a 61-year-old female who has been struggling with her hip for the past 24 weeks, maybe longer if she is being honest, though she says it has gotten worse in the last couple of months. Maria Jones describes a deep, aching pain in the groin, sometimes radiating toward the thigh, and it tends to tighten up if she sits too long. She has tried biking, swimming, hiking instead of walking, but feels overall things are slowly getting worse. She has stated she misses hiking more than anything in the world and needs this to be fixed as soon as possible because she wants to climb Mount Everest.

## Past Medical History:

Obstructive sleep apnea, Smoking, Diabetes

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 29.0. Antalgic gait. Hip ROM limited: flexion 91°, IR 7°, ER 22°. Leg length discrepancy 1.2 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We went over the imaging together and talked through the diagnosis and possible treatment paths. Given the severity of the hip condition, a total hip replacement would be a good option. We’ll start preparing for surgery, but first, it’s important to make sure the diabetes is well managed. I’ll coordinate with the primary care doctor to get the HbA1c below 8% before moving forward. We’ll plan to meet again in about three weeks to check progress and finalize the next steps.

# Chart 7

Patient Name: Patricia Taylor

Age/Sex: 77-year-old female

MRN: HR0007

Visit Date: 2025-08-05

Chief Complaint: Difficulty with bending down to put on shoes or socks

This is a 68-year-old female who reports struggling with hip pain for the past 52 weeks. She describes a noticeable worsening in the past couple of months. She has not had any prior hip injections. She denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain is currently rated 9/10, reaching up to 10/10 on her worst days.

She has said that her hip pain became truly unbearable the night she found herself sprinting after her neighbor’s runaway goat—which had somehow escaped its pen and was making a determined dash toward the community garden. She jokes that she was “running on pure adrenaline and stubbornness,” but the pain that followed the next morning was “the final straw.” Since then, every step has been a reminder that the goat may have won that battle, but she’s ready to win the war against her hip.

Past Medical History:

Obstructive sleep apnea, GERD

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 40.1. Antalgic gait. Hip ROM limited: flexion 95°, IR 8°, ER 21°. Leg length discrepancy 2.0 cm. Pain with a log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We sat down together to look over the imaging and talk through the diagnosis along with the possible treatment paths. Given her current BMI over 40, I explained that achieving at least a 10% weight reduction before surgery would be an important step to improve both safety and long-term outcomes. She was understanding of this and open to working toward that goal. We agreed to meet again in about three weeks to reassess progress and plan the next steps forward.

# Chart 8

Patient Name: Mary Miller

Age/Sex: 58-year-old female

MRN: HR0008

Visit Date: 2025-08-28

Chief Complaint: Hip stiffness

## History of Present Illness (HPI):

This is a 61-year-old female who has been struggling with her hip for the past 27 weeks, likely longer if she is being honest, though she reports a sharp worsening over the last couple of months. Mary Miller describes a deep, constant aching pain in the groin, radiating down toward the thigh, often accompanied by stabbing jolts if she twists or bears weight unevenly. Prolonged sitting makes the hip feel locked; even a brief half-hour of television leaves her nearly frozen, and when she stands, she winces through the first 15–20 steps before the joint grudgingly loosens. Everyday tasks have become major hurdles—putting on socks or shoes now often requires assistance, and she admits the loss of independence has been discouraging. Sleep is poor, as rolling onto her side wakes her with sharp pain.

Conservative measures have included Tylenol (short-lived relief), meloxicam (blunts the edge but not the spikes of pain), tramadol at night (helps but leaves her groggy and unsteady in the morning), six weeks of PT (improved strength but not pain), cane use intermittently, and heat packs with minimal temporary benefit. A corticosteroid injection 10 weeks ago provided ~78% relief, but only for about three weeks. She denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain is currently 6/10 at rest, flaring to 8–9/10 with activity. On her worst days, even standing at the sink to wash dishes is unbearable. Walking tolerance is now limited to ~300 feet before she must stop due to pain. She has tried swimming as an alternative exercise, but even the gentle kicking motions aggravate her hip, leaving her increasingly worried that her mobility is slipping away.

When sharing how this has impacted her family, she admitted with a wry smile that her grandchildren have turned her painful stiffness into a running household story. They’ve started calling her “The Tin Woman,” claiming she creaks and halts like the Tin Man needing oil. One afternoon, her 7-year-old grandson staged a dramatic “rescue mission,” running across the living room with a plastic ketchup bottle filled with water, insisting it would “fix her rusty hip.” Mary laughed at the memory, but then grew quiet—explaining that while their playfulness lightens the mood, she worries about how long she’ll be able to keep up with them at all if things continue this way.

## Past Medical History:

GERD, Smoking

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 39.0. Antalgic gait. Hip ROM limited: flexion 88°, IR 5°, ER 21°. Leg length discrepancy 1.9 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed her imaging together and talked through both the diagnosis and treatment options. Since she received a corticosteroid injection less than 12 weeks ago, it is safest to hold off on hip replacement surgery until the recommended interval has passed. In the meantime, she will continue with supportive measures, and we will plan to see her back in about three weeks to reassess her symptoms and move forward with planning

# Chart 9

Patient Name: David Lopez

Age/Sex: 67-year-old male

MRN: HR0009

Visit Date: 2025-08-14

Chief Complaint: Difficulty with bending down to put on shoes or socks

## History of Present Illness (HPI):

This is a 64-year-old male who has been struggling with his hip for the past 36 weeks, maybe longer if he is being honest, though he says it has gotten worse in the last couple of months. No prior hip injections. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 7/10, up to 8/10 on bad days. Walking tolerance is about 800 feet before stopping. He has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

Hyperlipidemia, Hypertension, GERD

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 41.3. Antalgic gait. Hip ROM limited: flexion 85°, IR 0°, ER 24°. Leg length discrepancy 1.4 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We went over the imaging together and talked through what’s going on with his hip as well as the treatment options available. Given his BMI over 40, I explained that reaching at least a 10% weight reduction before surgery would make the procedure both safer and more successful in the long run. I reassured him that this is a common step and that we’ll work together on realistic strategies to get there. We’ll plan to meet again in about three weeks to check on his progress and revisit the next steps.

# Chart 10

Patient Name: Joseph Davis

Age/Sex: 84-year-old male

MRN: HR0010

Visit Date: 2025-08-14

Chief Complaint: Hip stiffness

## History of Present Illness (HPI):

This is a 71-year-old male who has been struggling with his hip for the past 65 weeks, maybe longer if he is being honest, though he reports things have worsened over the last couple of months. Putting on socks or shoes has become difficult, sometimes needing help, which frustrates his independence. He has tried swimming instead of walking, but overall feels things are slowly getting worse.

When talking about how the hip has interfered with his hobbies, he chuckled and admitted it’s even disrupted his coin collecting. He explained that bending down to fetch a dropped coin has become nearly impossible, so he’s recruited his grandkids as “junior treasure hunters.” He swears they intentionally scatter his quarters around the living room just to watch him grimace and negotiate with them for each one back. He jokes that his prized collection of silver dollars is now “under hostile takeover” by a five-year-old who insists on being paid in gummy bears for every coin retrieved.

## Past Medical History:

Smoking, Hypertension, Obstructive sleep apnea, Diabetes

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.3 ppd × 19 yrs. Occasional marijuana use.

## Exam:

BMI 42.3. Antalgic gait. Hip ROM limited: flexion 88°, IR 8°, ER 15°. Leg length discrepancy 1.1 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed the imaging together and talked through the diagnosis along with the treatment options. Given his BMI over 40, I recommended working toward at least a 10% weight reduction before moving ahead with surgery. We also discussed the importance of coordinating with his primary care physician to optimize his diabetes management and bring his HbA1c below 8%. Because he is an active smoker, I emphasized that stopping nicotine use is essential for safe healing, and that cotinine testing will be required before surgery. He listened carefully but admitted he feels hesitant about making so many changes at once, worried it may be overwhelming. I reassured him that we can take it step by step, and that each change will not only help with surgery but also his overall health. We agreed to meet again in three weeks to check in on progress and reassess the plan.

# Chart 11

Patient Name: Linda Hernandez

Age/Sex: 66-year-old female

MRN: HR0011

Visit Date: 2025-07-10

Chief Complaint: Difficulty with bending down to put on shoes or socks

## History of Present Illness (HPI):

This is a 69-year-old female who has been struggling with her hip for the past 57 weeks, maybe longer if she is being honest, though she reports it has gotten noticeably worse over the past couple of months. She notes that even watching the wall for 5 minutes leaves her stiff when standing, needing 40 steps before the hip loosens. Pain is currently 7/10, rising to 8/10 on bad days. Walking tolerance is limited to about 700 feet before stopping. S

She shared with a sigh that her hip pain became especially discouraging on a recent family trip to Disney World. While her grandchildren darted from ride to ride, she found herself struggling to keep up—timing her breaks to the length of the lines and using benches as much as the attractions themselves. She joked that she saw more of the park benches than Cinderella’s castle, and admits the trip drove home just how much her mobility has slipped. Still, she smiled when recalling how her grandkids insisted she was the “VIP guest” of the trip, because she always had a place saved for them to rest when their little legs got tired too.

## Past Medical History:

Obstructive sleep apnea, Hyperlipidemia, Blood clot

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 45.8. Antalgic gait. Hip ROM limited: flexion 93°, IR 3°, ER 18°. Leg length discrepancy 1.8 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Recent injection <12 weeks; defer arthroplasty until safe interval passes.

# Chart 12

Patient Name: Elizabeth Moore

Age/Sex: 65-year-old female

MRN: HR0012

Visit Date: 2025-08-14

Chief Complaint: Pain in the lateral thigh

## History of Present Illness (HPI):

Elizabeth Moore reports hip pain for the past 29 weeks, describing crepitus with hip motion and stiffness after periods of inactivity. Symptoms are especially noticeable in the mornings, with aching pain that worsens with activity and improves somewhat with rest. She currently rates her pain at 8/10. Walking tolerance is limited to about 300 feet before stopping. She has tried Tylenol, meloxicam, tramadol, heat, and physical therapy, with only partial or temporary relief. She has not had prior hip injections. She denies systemic symptoms, has no history of cancer, and no prior hip surgery.

Elizabeth added, with a touch of exasperation, that she is convinced the hot summer weather is making everything worse. She explained that “the heat just bakes the joints,” and claims she can predict a sweltering day before she even looks outside, based on how stiff and sore her hip feels when she gets out of bed. She joked that if the meteorologists are ever wrong, they should just call her—“my hip is more reliable than the evening forecast.”

## Past Medical History:

Blood clot, GERD

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.2 ppd × 29 yrs. No illicit drug use.

## Exam:

BMI 47.5. Antalgic gait. Hip ROM limited: flexion 94°, IR 9°, ER 30°. Leg length discrepancy 1.3 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed the imaging together and talked through the diagnosis and available treatment options. With her BMI over 40, I recommended working toward at least a 10% weight reduction prior to surgery to help improve safety and recovery. We also discussed the importance of stopping nicotine use, and I explained that cotinine testing will be needed before moving forward with surgery. She expressed some hesitation, noting that the recent stretch of hot weather has made it even harder for her to stay active or focus on lifestyle changes—she worries that the heat worsens her hip pain and limits her ability to exercise outdoors. I reassured her that these challenges are common and encouraged small, sustainable adjustments that can still move her toward her goals. We agreed to meet again in three weeks to reassess her progress.

# Chart 13

Patient Name: Michael Gonzalez

Age/Sex: 55-year-old male

MRN: HR0013

Visit Date: 2025-06-26

Chief Complaint: Hip or groin pain

## History of Present Illness (HPI):

Michael Gonzalez reports hip pain for the past 71 weeks, describing crepitus with hip motion, aching that worsens with activity and improves with rest, and reduced hip range of motion with pain at the extremes. He currently rates his pain as 8/10, and his walking tolerance is limited to about 900 feet before needing to stop. He has tried Tylenol, meloxicam, tramadol, heat, and physical therapy, with limited benefit. A corticosteroid injection 23 weeks ago provided about 79% relief, though it lasted only about 8 weeks. He denies systemic symptoms, has no cancer history, and no prior hip surgery.

During the visit, Michael frequently circled back to stories of his younger days as a star athlete. He proudly recalled his years on the baseball field, describing in detail the time he hit a walk-off home run in the state finals, and how his hip now “feels like it’s still running the bases, only slower and rustier.” While discussing treatment options, he often veered into play-by-play accounts of games from decades ago, laughing at how his teammates nicknamed him “Rocket Legs.” He admitted, with a mix of pride and frustration, that it’s hard to reconcile those memories with his current limitations, joking that now even walking to the mailbox feels like running extra innings.

## Past Medical History:

Blood clot, Hyperlipidemia, Hypertension

## Past Surgical History:

Tonsillectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 25.8. Antalgic gait. Hip ROM limited: flexion 93°, IR 3°, ER 15°. Leg length discrepancy 1.3 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Return in 3 weeks for reassessment.

# Chart 14

Patient Name: Dorothy Rodriguez

Age/Sex: 82-year-old female

MRN: HR0014

Visit Date: 2025-06-09

Chief Complaint: Hip or groin pain

## History of Present Illness (HPI):

This is a 62-year-old female who has been struggling with her hip for the past 28 weeks, though she admits it may have been longer, with symptoms worsening in the last couple of months. Dorothy Rodriguez describes a deep, grinding ache in the groin that sometimes shoots like a sharp twinge down toward the thigh. She explains that the hip often feels “locked,” especially after sitting at her sewing machine for a stretch of time—when she stands, she needs several steps before it loosens, and those first moments feel as if the joint is bound by a tight strap. Everyday tasks such as putting on socks or shoes have become increasingly difficult, sometimes requiring assistance, which she finds discouraging.

She has not had prior hip injections. She denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain is currently 7/10, escalating to 8/10 on bad days. Walking tolerance is about 400 feet before needing to stop. She has tried swimming as a gentler alternative to walking but feels that, overall, things are continuing to worsen.

She smiled wistfully when asked about her goals, sharing her dream of someday becoming a figure skater and even joking about competing in the Olympics. Watching skaters on TV inspires her, but she admits her hip pain makes even basic movements feel clumsy and stiff, far removed from the fluidity she longs for on the ice. Still, she insists holding onto this dream gives her motivation—something to imagine when the pain feels most limiting.

## Past Medical History:

Hypertension, Diabetes

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 36.3. Antalgic gait. Hip ROM limited: flexion 89°, IR 2°, ER 18°. Leg length discrepancy 1.1 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Diabetes—coordinate with PCP to optimize HbA1c <8%. Return in 3 weeks for reassessment.

# Chart 15

Patient Name: William Davis

Age/Sex: 83-year-old male

MRN: HR0015

Visit Date: 2025-08-21

Chief Complaint: Difficulty with bending down to put on shoes or socks

## History of Present Illness (HPI):

This is a 70-year-old male who has been struggling with his hip for the past 62 weeks.. Putting on socks or shoes has become difficult, sometimes needing help, which frustrates his independence. Conservative measures have included Tylenol (helpful briefly), meloxicam (takes the edge off), tramadol at night (causing grogginess), six weeks of PT (gained strength but pain persisted), cane use at times, and heat packs for temporary relief. Corticosteroid injection 24 weeks ago with about 61% relief for 8 weeks.

Past Medical History:

GERD, Blood clot, Smoking

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 32.5. Antalgic gait. Hip ROM limited: flexion 90°, IR 1°, ER 20°. Leg length discrepancy 2.0 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Return in 3 weeks for reassessment.

# Chart 16

Patient Name: Christopher Smith

Age/Sex: 78-year-old male

MRN: HR0016

Visit Date: 2025-06-14

Chief Complaint: Hip or groin pain

## History of Present Illness (HPI):

This is a 71-year-old male who has been struggling with his hip for as long as he can remember. Christopher Smith describes a deep, aching pain in the groin, sometimes radiating toward the thigh, and it tends to tighten up if he sits too long. No prior hip injections. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 6/10, up to 8/10 on bad days. Walking tolerance is about 300 feet before stopping. He has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

GERD, Hyperlipidemia

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 0.6 ppd × 30 yrs. Remote cocaine use (no current use).

## Exam:

BMI 32.0. Antalgic gait. Hip ROM limited: flexion 91°, IR 5°, ER 18°. Leg length discrepancy 1.1 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 17

Patient Name: Robert Anderson

Age/Sex: 70-year-old male

MRN: HR0017

Visit Date: 2025-06-19

Chief Complaint: Hip stiffness

## History of Present Illness (HPI):

This is a 64-year-old male who has been struggling with his hip for the past 38 weeks, though he admits it may have been longer, with symptoms worsening in the last couple of months. He reports increasing difficulty playing with his grandchildren and even putting on clothes in a timely manner due to stiffness and pain.

Conservative measures have included Tylenol (helpful briefly), meloxicam (takes the edge off), tramadol at night (causes grogginess), six weeks of PT (he gained strength but the pain persisted), cane use at times, and heat packs with temporary relief. A corticosteroid injection 20 weeks ago provided about 58% relief, lasting for 6 weeks. He denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain is currently 8/10, rising to 8/10 on bad days, with walking tolerance of about 600 feet before stopping. He has attempted swimming instead of walking, but feels overall things are slowly worsening.

As he spoke about his hip, he drifted into a story from his time in the service. He recalled long marches carrying heavy packs, how the cold and damp would seep into his joints, and how back then he could push through without a second thought. He laughed wryly that “the hip’s probably been plotting its revenge ever since those 20-mile hikes.” He compared today’s pain to that same grinding stiffness he felt crouched in the mud during field drills—only now, there’s no adrenaline or camaraderie to distract him. He admits it’s hard to accept that the man who once trudged through endless terrain now struggles to make it 600 feet without stopping.

## Past Medical History:

Diabetes, Hypertension, Smoking, Obstructive sleep apnea

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 45.9. Antalgic gait. Hip ROM limited: flexion 93°, IR 1°, ER 22°. Leg length discrepancy 1.7 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We sat together to review his imaging and discuss both the diagnosis and treatment options. Given his BMI over 40, I explained that working toward at least a 10% weight reduction will be an important step in making surgery safer and improving recovery. We also discussed his diabetes, and I recommended coordination with his primary care physician to bring his HbA1c below 8% before proceeding. He listened carefully, asked thoughtful questions, and acknowledged that these changes may be challenging, but he expressed a willingness to try. We agreed to meet again in about three weeks to check his progress and revisit the next steps.

# Chart 18

Patient Name: Christopher Moore

Age/Sex: 64-year-old male

MRN: HR0018

Visit Date: 2025-06-01

Chief Complaint: Difficulty with bending down to put on shoes or socks

## History of Present Illness (HPI):

Christopher Moore reports hip pain for 69 weeks with reduced hip range of motion with pain at extremes, difficulty with walking, climbing stairs, rising from seated position, stiffness after inactivity, worse in mornings. Pain 8/10. Walk tolerance ~300 ft. Tried Tylenol, meloxicam, tramadol, heat, PT. No prior hip injections. Denies systemic symptoms, no cancer history, no prior hip surgery.

## Past Medical History:

Smoking, Hyperlipidemia, Blood clot

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.1 ppd × 16 yrs. Remote cocaine use (no current use).

## Exam:

BMI 31.7. Antalgic gait. Hip ROM limited: flexion 90°, IR 7°, ER 15°. Leg length discrepancy 1.8 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 19

Patient Name: Joseph Thomas

Age/Sex: 84-year-old male

MRN: HR0019

Visit Date: 2025-06-13

Chief Complaint: Difficulty with bending down to put on shoes or socks

## History of Present Illness (HPI):

Joseph Thomas reports hip pain for 27 weeks with stiffness after inactivity, worse in mornings, aching worsened by activity and improved with rest, crepitus with hip motion. Pain 9/10. Walk tolerance ~800 ft. Tried Tylenol, meloxicam, tramadol, heat, PT. No prior hip injections. Denies systemic symptoms, no cancer history, no prior hip surgery.

## Past Medical History:

Hyperlipidemia, Diabetes, GERD, Hypertension

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 25.1. Antalgic gait. Hip ROM limited: flexion 90°, IR 10°, ER 23°. Leg length discrepancy 1.6 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Diabetes—coordinate with PCP to optimize HbA1c <8%. Return in 3 weeks for reassessment.

# Chart 20

Patient Name: William Jones

Age/Sex: 63-year-old male

MRN: HR0020

Visit Date: 2025-08-07

Chief Complaint: Hip or groin pain

## History of Present Illness (HPI):

William Jones reports hip pain for the last 2 years with crepitus with hip motion, reduced hip range of motion with pain at extremes, aching worsened by activity and improved with rest. Pain 8/10. Walk tolerance ~700 ft. Tried Tylenol, meloxicam, tramadol, heat, PT. No prior hip injections. Denies systemic symptoms, no cancer history, no prior hip surgery.

## Past Medical History:

Blood clot, Smoking, Obstructive sleep apnea

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.3 ppd × 34 yrs. No illicit drug use.

## Exam:

BMI 27.1. Antalgic gait. Hip ROM limited: flexion 87°, IR 4°, ER 17°. Leg length discrepancy 1.2 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 21

Patient Name: Maria Jones

Age/Sex: 65-year-old female

MRN: HR0021

Visit Date: 2025-06-19

Chief Complaint: Pain radiating from groin to the level of the knee

## History of Present Illness (HPI):

Maria Jones reports hip pain for 31 weeks with stiffness after inactivity, worse in mornings, crepitus with hip motion, swelling and end-of-day pain. Pain 7/10. Walk tolerance ~500 ft. Tried Tylenol, meloxicam, tramadol, heat, PT. No prior hip injections. Denies systemic symptoms, no cancer history, no prior hip surgery.

## Past Medical History:

Obstructive sleep apnea, Diabetes, Hyperlipidemia, Smoking

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 42.3. Antalgic gait. Hip ROM limited: flexion 85°, IR 0°, ER 23°. Leg length discrepancy 1.4 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. BMI >40; advised ≥10% weight reduction before surgery. Diabetes—coordinate with PCP to optimize HbA1c <8%. Return in 3 weeks for reassessment.

# Chart 22

Patient Name: Christopher Martinez

Age/Sex: 84-year-old male

MRN: HR0022

Visit Date: 2025-07-19

Chief Complaint: Catching or locking in groin

## History of Present Illness (HPI):

This is a 73-year-old male who has been struggling with his hip for the past 74 weeks, though he admits it may have been longer, with worsening in the last couple of months. Christopher Martinez tries to describe his pain, though his account is tangled and meandering. He says it’s “a deep ache in the groin, but not always the groin—sometimes the thigh, unless I sit too long, in which case it feels like the hip is made of cement, except when it isn’t, and then it’s more like someone’s wedged a rock in there.” He explains that if he sits still for a stretch, like during church or while reading, standing up feels as though “the gears are stuck,” and it takes a dozen steps before things grind loose again. When he puts on socks or shoes, the pain is sharper—“like something’s being pinched, though not always, sometimes more of a pull, or maybe a jammed hinge”—and he admits it frustrates his independence.

Conservative measures have included Tylenol (briefly helpful), meloxicam (dulls things but doesn’t erase them), tramadol at night (brings grogginess), six weeks of PT (improved strength but not the pain), cane use at times, and heat packs for fleeting relief. He has not had prior hip injections. He denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain is currently 8/10, though he jokes it feels like “a 9 when I walk, a 7 when I sit, and maybe a 12 when I try to bend over—depending on the shoes.” Walking tolerance is about 600 feet before stopping. He has tried swimming, but says “even floating makes the joint complain, like it doesn’t trust the water either.” Overall, he feels things are slowly worsening.

Threaded through his story, Christopher repeatedly returned to a travel memory of a bus tour in Italy. He described getting left behind in Florence after stopping to tie his shoe, convinced he could catch up, only to trail the wrong bus for miles. “Funny thing,” he added, “the hip now feels just like that day—like I’m chasing something that keeps moving away, except this time it’s comfort, and I can’t catch it.” His recollection weaved in and out of our discussion, sometimes muddling his description of pain further, but ultimately highlighting the frustration of how far he has drifted from the days when chasing the wrong bus for miles was a nuisance instead of an impossibility.

## Past Medical History:

Obstructive sleep apnea, Blood clot

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 44.9. Antalgic gait. Hip ROM limited: flexion 86°, IR 6°, ER 25°. Leg length discrepancy 1.1 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We sat together to review his imaging and go over the diagnosis along with possible treatment options. Given his BMI over 40, I explained that aiming for at least a 10% weight reduction would be an important step in making surgery safer and recovery smoother. He nodded, though he joked that losing weight might be harder than keeping up with that runaway bus in Florence years ago. We agreed to focus on steady, realistic progress, and he will continue conservative measures in the meantime. We plan to meet again in about three weeks to check on his progress and revisit the next steps.

# Chart 23

Patient Name: Barbara Jackson

Age/Sex: 77-year-old female

MRN: HR0023

Visit Date: 2025-07-26

Chief Complaint: Pain radiating from groin to the level of the knee

## History of Present Illness (HPI):

This is a 63-year-old female who has been struggling with her hip for the past 35 weeks, maybe longer if she is being honest, though she says it has gotten worse in the last couple of months. She says that if she sits to watch TV for a half hour, when she stands, the first dozen steps feel stiff until the hip loosens. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 9/10, up to 8/10 on bad days.

Past Medical History:

Smoking, Obstructive sleep apnea

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 24.6. Antalgic gait. Hip ROM limited: flexion 91°, IR 2°, ER 24°. Leg length discrepancy 1.0 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed the imaging together and talked about what the pictures showed. I explained the diagnosis and the different treatment options, and we agreed that a total hip replacement would be the best way forward. We’ll get started on the pre-op planning so everything is ready when the time comes. He asked when he could “get the new hip” and seemed eager to move things along, though I reminded him there are steps we have to follow first. We’ll check back again in three weeks to see how things are going.

# Chart 24

Patient Name: Thomas Jones

Age/Sex: 65-year-old male

MRN: HR0024

Visit Date: 2025-06-26

Chief Complaint: Hip or groin pain

## History of Present Illness (HPI):

Thomas Jones reports hip pain for 68 weeks with swelling and end-of-day pain, difficulty with walking, climbing stairs, rising from seated position, reduced hip range of motion with pain at extremes. Pain 9/10. Walk tolerance ~300 ft. Tried Tylenol, meloxicam, tramadol, heat, PT. No prior hip injections. Denies systemic symptoms, no cancer history, no prior hip surgery.

## Past Medical History:

Hyperlipidemia, GERD, Hypertension

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 41.1. Antalgic gait. Hip ROM limited: flexion 88°, IR 10°, ER 15°. Leg length discrepancy 1.4 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed the imaging and discussed the diagnosis along with treatment options. Given his BMI over 40, I advised working toward at least a 10% weight reduction before surgery to help reduce risks and improve recovery. He was reluctant with this recommendation, questioning whether the weight loss was truly necessary and expressing frustration that it might delay surgery. I explained the reasoning and emphasized safety, but he remained somewhat resistant. We agreed to revisit the discussion in three weeks at his next reassessment.

# Chart 25

Patient Name: Robert Martin

Age/Sex: 77-year-old male

MRN: HR0025

Visit Date: 2025-06-06

Chief Complaint: Pain radiating from groin to the level of the knee

## History of Present Illness (HPI):

This is a 63-year-old male describing a deep, aching pain in the groin, sometimes radiating toward the thigh, and it tends to tighten up if he sits too long. He says that if he sits to watch TV for a half hour, when he stands, the first dozen steps feel stiff until the hip loosens. Conservative measures have included Tylenol (helpful briefly), meloxicam (takes the edge off), tramadol at night (causing grogginess), six weeks of PT (gained strength but pain persisted), cane use at times, and heat packs for temporary relief. Corticosteroid injection 17 weeks ago with about 48% relief for 3 weeks. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 6/10, up to 8/10 on bad days. Walking tolerance is about 900 feet before stopping. He has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

Hyperlipidemia, GERD, Diabetes

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 0.6 ppd × 9 yrs. Remote cocaine use (no current use).

## Exam:

BMI 40.9. Antalgic gait. Hip ROM limited: flexion 87°, IR 6°, ER 29°. Leg length discrepancy 1.4 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. BMI >40; advised ≥10% weight reduction before surgery. Diabetes—coordinate with PCP to optimize HbA1c <8%. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 26

Patient Name: Margaret Jackson

Age/Sex: 72-year-old female

MRN: HR0026

Visit Date: 2025-08-06

Chief Complaint: Catching or locking in groin

## History of Present Illness (HPI):

Margaret Jackson reports hip pain for 44 weeks with crepitus with hip motion, swelling and end-of-day pain, reduced hip range of motion with pain at extremes. Pain 8/10. Walk tolerance ~400 ft. Tried Tylenol, meloxicam, tramadol, heat, PT. Corticosteroid injection 17 weeks ago with about 73% relief for 3 weeks. Denies systemic symptoms, no cancer history, no prior hip surgery.

## Past Medical History:

Hypertension, Hyperlipidemia, Diabetes

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 29.6. Antalgic gait. Hip ROM limited: flexion 91°, IR 9°, ER 19°. Leg length discrepancy 1.9 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Diabetes—coordinate with PCP to optimize HbA1c <8%. Return in 3 weeks for reassessment.

# Chart 27

Patient Name: William Johnson

Age/Sex: 77-year-old male

MRN: HR0027

Visit Date: 2025-08-03

Chief Complaint: Hip or groin pain

## History of Present Illness (HPI):

William Johnson reports hip pain for the past 52 weeks, with crepitus on motion and aching discomfort that worsens with activity and improves with rest. He reports increasing difficulty with walking, climbing stairs, and rising from a seated position. Current pain is 7/10. Walking tolerance is about 700 feet before needing to stop. He has tried Tylenol (brief relief), meloxicam (takes the edge off), tramadol (causes grogginess at night), heat, and physical therapy. No prior hip injections. He denies systemic symptoms, has no cancer history, and no prior hip surgery.

In the middle of his history, William shifted into a story about a trip to Los Angeles last year, where his hip “officially betrayed him.” He explained that while visiting the Hollywood Walk of Fame, he tried to squat down to take a picture with his favorite star on the sidewalk—but his hip locked halfway down, leaving him frozen in a half-crouch as tourists streamed around him. He said a street performer dressed as Spider-Man eventually offered him a hand up, “probably the most heroic thing that Spider-Man did all day.” Ever since then, he says, the hip has been a constant reminder that he can’t move the way he once did.

## Past Medical History:

Blood clot, GERD

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 37.1. Antalgic gait. Hip ROM limited: flexion 91°, IR 4°, ER 15°. Leg length discrepancy 1.5 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Return in 3 weeks for reassessment.

# Chart 28

Patient Name: Joseph Martinez

Age/Sex: 61-year-old male

MRN: HR0028

Visit Date: 2025-06-12

Chief Complaint: Difficulty with bending down to put on shoes or socks

## History of Present Illness (HPI):

This is a 63-year-old male who has been struggling with his hip for the past 35 weeks, maybe longer if he is being honest, though he says it has gotten worse in the last couple of months. Joseph Martinez describes a deep, aching pain in the groin, sometimes radiating toward the thigh, and it tends to tighten up if he sits too long. He says that if he sits to watch TV for a half hour, when he stands, the first dozen steps feel stiff until the hip loosens. Putting on socks or shoes has become difficult, sometimes needing help, which frustrates his independence. Conservative measures have included Tylenol (helpful briefly), meloxicam (takes the edge off), tramadol at night (causing grogginess), six weeks of PT (gained strength but pain persisted), cane use at times, and heat packs for temporary relief. Corticosteroid injection 16 weeks ago with about 43% relief for 4 weeks. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 9/10, up to 8/10 on bad days. Walking tolerance is about 400 feet before stopping. He has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

Blood clot, Obstructive sleep apnea

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.3 ppd × 23 yrs. No illicit drug use.

## Exam:

BMI 48.5. Antalgic gait. Hip ROM limited: flexion 94°, IR 9°, ER 24°. Leg length discrepancy 1.8 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. BMI >40; advised ≥10% weight reduction before surgery. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 29

Patient Name: Barbara Jackson

Age/Sex: 65-year-old female

MRN: HR0029

Visit Date: 2025-06-08

Chief Complaint: Limping and pain

## History of Present Illness (HPI):

This is a 71-year-old female who has been dealing with hip pain for many years, though she feels it has noticeably worsened recently. She describes the discomfort less as a sharp pain and more like a heavy, grinding pressure deep in the joint, as if the hip is “carrying sandbags.” The stiffness is most noticeable after sitting still—she explains that when she first stands, the joint feels locked, and she has to shuffle several steps before it begins to move more freely. Bending to put on socks or shoes has become a frustrating challenge, often requiring assistance.

She has tried multiple conservative measures: Tylenol (only briefly helpful), meloxicam (takes the edge off), tramadol at night (helps somewhat but leaves her foggy), six weeks of PT (gained strength but no lasting relief), occasional cane use, and heat packs (soothing but short-lived). No prior hip injections. She denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently averages 9/10, with peaks that feel “like a jammed hinge” on bad days. Walking tolerance is about 600 feet before she needs to stop and rest. She has attempted swimming, which feels gentler, though she notes the hip still stiffens afterward and progress overall has been discouraging.

She recounted with a laugh that one of the worst flare-ups came during a family hockey game years ago. Wanting to impress her grandchildren, she laced up a pair of skates for the first time in decades, only to have her hip lock after a few laps. She wobbled into the boards, declaring herself “retired from the NHL” on the spot. Her family still jokes that she gave herself the hardest body check of the game, and she admits that ever since then, the hip has been a constant reminder of that day on the ice.

## Past Medical History:

Obstructive sleep apnea, Smoking

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.3 ppd × 26 yrs. Remote cocaine use (no current use).

## Exam:

BMI 45.8. Antalgic gait. Hip ROM limited: flexion 91°, IR 5°, ER 27°. Leg length discrepancy 1.7 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed her imaging together and discussed the diagnosis as well as treatment options. With a BMI greater than 40, I recommended working toward at least a 10% weight reduction before moving ahead with surgery, both to improve safety and to support recovery. Because she is an active smoker, we also discussed the importance of nicotine cessation, and I explained that cotinine testing will be needed before surgery can proceed. She understood the reasoning, though she expressed some concern about making both changes at once. I reassured her that progress can be taken step by step and encouraged her to use this time to focus on gradual improvement. We agreed to follow up in three weeks to check her progress and reassess next steps.

# Chart 30

Patient Name: Elizabeth Williams

Age/Sex: 74-year-old female

MRN: HR0030

Visit Date: 2025-06-24

Chief Complaint: Anterior thigh pain associated with hip range of motion or weight bearing

## History of Present Illness (HPI):

Elizabeth Williams reports hip pain for the past 48 weeks. She notes increasing difficulty with walking, climbing stairs, and rising from a seated position. The pain is described as a persistent ache that worsens with activity and improves somewhat with rest. She also reports swelling and more pronounced discomfort at the end of the day. Current pain is 6/10. Walking tolerance is about 800 feet before stopping. She has tried Tylenol (brief benefit), meloxicam (takes the edge off), tramadol (nighttime use, causes grogginess), heat, and physical therapy. Corticosteroid injection 8 weeks ago provided about 48% relief, lasting for 6 weeks. She denies systemic symptoms, has no cancer history, and no prior hip surgery.

While reflecting on how her hip has slowed her down, Elizabeth shared a story about traveling to London several years ago for Wimbledon. She laughed about how she nearly missed her chance to see Centre Court because her hip began acting up as she climbed the long stairways at the stadium. She joked that the hip was “in open rebellion” by the time she reached her seat, forcing her to spend the first set stretching in the aisle while ushers looked on with mild disapproval. Despite the pain, she called it one of her favorite memories—watching tennis at Wimbledon while “secretly competing with the players” to see who looked stiffer getting up between sets, her or the athletes after long rallies.

## Past Medical History:

Obstructive sleep apnea, Hyperlipidemia, Diabetes

## Past Surgical History:

Tonsillectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 0.7 ppd × 22 yrs. Remote cocaine use (no current use).

## Exam:

BMI 29.5. Antalgic gait. Hip ROM limited: flexion 95°, IR 1°, ER 28°. Leg length discrepancy 1.4 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed her imaging together and discussed the diagnosis along with possible treatment options. Since she received a corticosteroid injection less than 12 weeks ago, I explained that it is safest to defer hip replacement until the appropriate interval has passed. We also talked about her diabetes, and I recommended she coordinate with her primary care physician to optimize control and bring her HbA1c below 8% before moving forward. Because she is an active smoker, I emphasized the importance of stopping nicotine use, noting that cotinine testing will be required prior to surgery. She acknowledged the recommendations and we agreed to follow up in three weeks to reassess progress and revisit the plan.

# Chart 31

Patient Name: David Williams

Age/Sex: 57-year-old male

MRN: HR0031

Visit Date: 2025-06-03

Chief Complaint: Catching or locking in groin

## History of Present Illness (HPI):

This is a 72-year-old male who has been struggling with hip pain for the past 70 weeks, though he admits it may have been present longer, with symptoms worsening in the last couple of months. Instead of calling it sharp, he describes the pain as a constant heaviness deep in the joint—“like dragging around a sandbag.” At times it sends a dull pull into his thigh, especially after he’s been sitting. He explains that when he stands after sitting, the hip feels locked in place, forcing him to shuffle stiffly until it begins to move again. He says the joint “doesn’t trust him anymore,” unpredictable in how it stiffens or gives way. Tasks such as bending to put on socks or shoes now feel clumsy, awkward, and time-consuming, often requiring help, which he finds discouraging.

As he spoke, David drifted into a story about the local summer corn festival. He recalled how, in a burst of confidence, he entered the corn maze with his grandson, determined to prove he could keep up. Halfway through, his hip locked so badly that he had to stop, leaning against the stalks while children zipped past him. Eventually, his family discovered him sitting on a hay bale at the maze’s exit, “defeated by corn.” He now jokes that his hip pain has turned cornfields into enemy territory and admits he hasn’t stepped into a maze since, fearing he might never make it out.

Past Medical History:

Smoking, Obstructive sleep apnea, Hypertension, Diabetes

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 32.7. Antalgic gait. Hip ROM limited: flexion 89°, IR 7°, ER 17°. Leg length discrepancy 1.5 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed his imaging together and discussed the diagnosis as well as treatment options. He is an appropriate candidate for total hip arthroplasty, and we will move forward with pre-operative planning. Because of his diabetes, I advised coordination with his primary care physician to optimize blood sugar control and bring his HbA1c below 8% before surgery. He nodded and joked that managing his diet might be harder than escaping last summer’s corn maze, where his hip gave out halfway through and left him stranded until his family came to find him. We agreed to follow up in three weeks to check on his progress and finalize the next steps.

# Chart 32

Patient Name: Michael Taylor

Age/Sex: 64-year-old male

MRN: HR0032

Visit Date: 2025-06-26

Chief Complaint: Anterior thigh pain associated with hip range of motion or weight bearing

## History of Present Illness (HPI):

This is a 70-year-old male who has been struggling with his hip for the past 63 weeks, maybe longer if he is being honest, though he says it has gotten worse in the last couple of months. Putting on socks or shoes has become difficult, sometimes needing help, which frustrates his independence. Conservative measures have included Tylenol (helpful briefly), meloxicam (takes the edge off), tramadol at night (causing grogginess). Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 6/10, up to 8/10 on bad days. Walking tolerance is about 600 feet before stopping. He has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

Blood clot, Obstructive sleep apnea, Diabetes, Hypertension

## Past Surgical History:

Appendectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 46.7. Antalgic gait. Hip ROM limited: flexion 91°, IR 9°, ER 28°. Leg length discrepancy 1.2 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Recent injection <12 weeks; defer arthroplasty until safe interval passes. Diabetes—coordinate with PCP to optimize HbA1c <8%. Return in 3 weeks for reassessment.

# Chart 33

Patient Name: Christopher Taylor

Age/Sex: 83-year-old male

MRN: HR0033

Visit Date: 2025-07-04

Chief Complaint: Pain in the lateral thigh

## History of Present Illness (HPI):

This is a 70-year-old male who has been struggling with his hip for the past 63 weeks, maybe longer if he is being honest, though he says it has gotten worse in the last couple of months. Christopher Taylor describes a deep, aching pain in the groin, sometimes radiating toward the thigh, and it tends to tighten up if he sits too long. He says that if he sits to watch TV for a half hour, when he stands, the first dozen steps feel stiff until the hip loosens. Putting on socks or shoes has become difficult, sometimes needing help, which frustrates his independence. Conservative measures have included Tylenol (helpful briefly), meloxicam (takes the edge off), tramadol at night (causing grogginess), six weeks of PT (gained strength but pain persisted), cane use at times, and heat packs for temporary relief. He has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

Hyperlipidemia, Obstructive sleep apnea

## Past Surgical History:

Tonsillectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.4 ppd × 23 yrs. Occasional marijuana use.

## Exam:

BMI 40.7. Antalgic gait. Hip ROM limited: flexion 87°, IR 4°, ER 29°. Leg length discrepancy 1.2 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed his imaging together and discussed the diagnosis along with possible treatment options. With his BMI greater than 40, I recommended working toward at least a 10% weight reduction before surgery to improve safety and outcomes. Because he is an active smoker, we also talked about nicotine cessation, and I explained that cotinine testing will be required before surgery can proceed. He listened but expressed doubt, questioning whether these steps were really necessary or if they were just “extra hoops” to delay surgery. I acknowledged his concerns, explained the medical reasons behind each recommendation, and reassured him that these measures are in place to reduce risks and support recovery. Despite his hesitation, he agreed to return in three weeks for reassessmen

# Chart 34

Patient Name: Maria Moore

Age/Sex: 60-year-old female

MRN: HR0034

Visit Date: 2025-08-11

Chief Complaint: Pain in the lateral thigh

## History of Present Illness (HPI):

Maria Moore reports hip pain for 75 weeks with stiffness after inactivity, worse in mornings, reduced hip range of motion with pain at extremes, difficulty with walking, climbing stairs, rising from seated position. Pain 9/10. Walk tolerance ~500 ft. Tried Tylenol, meloxicam, tramadol, heat, PT. No prior hip injections. Denies systemic symptoms, no cancer history, no prior hip surgery.

## Past Medical History:

Smoking, GERD, Hyperlipidemia, Blood clot

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 24.4. Antalgic gait. Hip ROM limited: flexion 89°, IR 4°, ER 17°. Leg length discrepancy 1.3 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Return in 3 weeks for reassessment.

# Chart 35

Patient Name: Joseph Smith

Age/Sex: 75-year-old male

MRN: HR0035

Visit Date: 2025-07-28

Chief Complaint: Catching or locking in groin

## History of Present Illness (HPI):

This is a 71-year-old male who reports a nagging hip pain that he describes less as sharp and more like “a knot deep in the joint that won’t untangle.” At times it feels like a dull weight pulling into the thigh, and other times he compares it to “a hinge that’s rusty in the morning and stiff again after sitting too long.” He explains that after sitting for a half hour, standing feels like trying to walk with one leg stuck in wet cement—the first dozen steps are stiff and awkward until things slowly loosen. Putting on socks or shoes has become a chore, requiring awkward maneuvering or occasional help, which he finds frustrating. He denies fevers, chills, weight loss, cancer history, or prior hip surgery. Current pain is rated 6/10, rising to 8/10 on bad days. Walking tolerance is about 700 feet before needing to stop. Swimming was attempted as an alternative exercise, but he feels the hip still “argues with every kick” and that overall things are gradually worsening.

While talking through his symptoms, he shared a lighthearted story about a bake sale. Determined to snag a chocolate croissant before they sold out, he underestimated how long it would take him to cross the room with his stiff hip. By the time he made it to the table, all that remained were bran muffins. He joked that the hip is sabotaging his pastry preferences, turning him from a croissant man into “the reluctant ambassador of bran.”

## Past Medical History:

Hyperlipidemia, GERD, Diabetes, Smoking

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 41.1. Antalgic gait. Hip ROM limited: flexion 87°, IR 4°, ER 17°. Leg length discrepancy 1.9 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed his imaging and went over the diagnosis along with treatment options. With a BMI greater than 40, I advised working toward at least a 10% weight reduction before proceeding with surgery to help reduce risks and improve recovery. We also discussed his diabetes, and I recommended coordinating with his primary care physician to optimize his HbA1c below 8% prior to surgery. He nodded, joking that managing his diet might feel like passing up a chocolate croissant for a bran muffin, but agreed that it’s necessary. We will follow up again in three weeks to reassess his progress and finalize the next steps.

# Chart 36

Patient Name: Michael Martin

Age/Sex: 72-year-old male

MRN: HR0036

Visit Date: 2025-07-08

Chief Complaint: Hip stiffness

## History of Present Illness (HPI):

Michael Martin describes a deep, aching pain in the groin, sometimes radiating toward the thigh, and it tends to tighten up if he sits too long. He says that if he sits to watch TV for a half hour, when he stands, the first dozen steps feel stiff until the hip loosens. Putting on socks or shoes has become difficult, sometimes needing help, which frustrates his independence. Corticosteroid injection 17 weeks ago with about 77% relief for 8 weeks. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 6/10, up to 8/10 on bad days. Walking tolerance is about 700 feet before stopping. He has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

Diabetes, Blood clot, Smoking

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 31.3. Antalgic gait. Hip ROM limited: flexion 86°, IR 8°, ER 21°. Leg length discrepancy 1.4 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed his imaging together and discussed the diagnosis as well as treatment options. He is an appropriate candidate for total hip arthroplasty, and we will begin pre-operative planning. Because of his diabetes, I advised coordination with his primary care physician to optimize his HbA1c below 8% prior to surgery. During our conversation, he expressed strong opinions about vaccines and voiced concern that this might somehow be tied to the surgical process. I clarified that vaccination is not a requirement for proceeding with hip arthroplasty, but emphasized the importance of infection prevention and overall health optimization in the perioperative period. We agreed to focus on the modifiable risk factors relevant to surgery and plan for reassessment in three weeks.

# Chart 37

Patient Name: Thomas Williams

Age/Sex: 63-year-old male

MRN: HR0037

Visit Date: 2025-07-28

Chief Complaint: Anterior thigh pain associated with hip range of motion or weight bearing

## History of Present Illness (HPI):

This is a 61-year-old male who has been struggling with his hip for the past 27 weeks, maybe longer if he is being honest, though he says it has gotten worse in the last couple of months. Corticosteroid injection 22 weeks ago with about 75% relief for 4 weeks. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 6/10, up to 8/10 on bad days. Walking tolerance is about 400 feet before stopping. He has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

Blood clot, Obstructive sleep apnea

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 33.7. Antalgic gait. Hip ROM limited: flexion 95°, IR 7°, ER 24°. Leg length discrepancy 1.2 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Return in 3 weeks for reassessment.

# Chart 38

Patient Name: Joseph Brown

Age/Sex: 71-year-old male

MRN: HR0038

Visit Date: 2025-07-04

Chief Complaint: Hip or groin pain

## History of Present Illness (HPI):

This is a 68-year-old male who has been struggling with hip pain for the past 53 weeks, though he admits it may have been longer, with noticeable worsening in the past couple of months. Instead of describing it as sharp, Joseph calls the pain “a heavy knot deep in the joint” that sometimes sends a dull, dragging pull down into the thigh. He explains it’s not constant in the same way every day—sometimes it feels like the joint is “glued shut,” other times it’s more like “a rusty hinge that squeaks when I try to move.” If he sits too long, the hip stiffens, and when he stands, he says the first dozen steps feel “like walking through molasses” until it loosens. Simple tasks such as putting on socks or shoes now feel clumsy and awkward, often requiring help, which frustrates him.

Conservative measures have included Tylenol (brief benefit), meloxicam (dulls the edge but doesn’t erase it), tramadol at night (helps somewhat but leaves him groggy), six weeks of PT (built strength but pain persisted), occasional cane use, and heat packs with only temporary relief. He has not had prior hip injections. He denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain is currently 8/10, with walking tolerance of about 800 feet before stopping. Swimming has been tried, but even gentle kicking seems to aggravate things, leaving him feeling overall that the problem is gradually worsening.

Joseph also shared a story about meeting Oprah years ago in a Chicago bookstore. He admitted his hip was aching even then, but he forced himself to stand tall, refusing to limp in front of her. When she asked how he was doing, he smiled and replied, “Better now.” He laughed at the memory, saying Oprah had a way of making him forget his hip for a moment—but unlike that day, he can’t ignore the pain anymore.

## Past Medical History:

Hypertension, Smoking, Blood clot

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 1.2 ppd × 34 yrs. Occasional marijuana use.

## Exam:

BMI 33.2. Antalgic gait. Hip ROM limited: flexion 85°, IR 6°, ER 29°. Leg length discrepancy 1.9 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 39

Patient Name: Linda Johnson

Age/Sex: 55-year-old female

MRN: HR0039

Visit Date: 2025-08-11

Chief Complaint: Catching or locking in groin

## History of Present Illness (HPI):

Linda Johnson describes a deep, aching pain in the groin, sometimes radiating toward the thigh, and it tends to tighten up if she sits too long. She says that if she sits to watch TV for a half hour, when she stands, the first dozen steps feel stiff until the hip loosens. Putting on socks or shoes has become difficult, sometimes needing help, which frustrates her independence. No prior hip injections. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 7/10, up to 8/10 on bad days. Walking tolerance is about 700 feet before stopping. She has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

Hypertension, Blood clot, Hyperlipidemia

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 29.9. Antalgic gait. Hip ROM limited: flexion 89°, IR 4°, ER 29°. Leg length discrepancy 1.3 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Return in 3 weeks for reassessment.

# Chart 40

Patient Name: Robert Rodriguez

Age/Sex: 59-year-old male

MRN: HR0040

Visit Date: 2025-07-11

Chief Complaint: Difficulty with bending down to put on shoes or socks

## History of Present Illness (HPI):

Robert Rodriguez reports hip discomfort that has been present for some time and feels worse over the past several months. He describes it only as “a deep soreness” that sometimes moves into the thigh but is otherwise difficult for him to pin down. He notes the joint tends to feel “tight” after sitting, and when he stands after about a half hour, his first several steps are slow and awkward before it eases. Pain is generally 7/10, rising to 8/10 on bad days, though he says it “just depends.” Walking tolerance is about 800 feet before he stops. He has tried swimming instead of walking, but overall feels things are gradually worsening.

In sharing his story, Robert compared his hip troubles to moments from The Office, laughing that when he first stands up, he shuffles like Stanley on Pretzel Day—moving reluctantly but determined to get somewhere. He added that at times his gait resembles Michael Scott’s clumsy dancing, “not pretty, but it gets me across the room.” He admits these jokes help lighten things, but beneath the humor he recognizes his hip continues to limit him more each week.

## Past Medical History:

Diabetes, Obstructive sleep apnea, Hypertension, Smoking

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.4 ppd × 23 yrs. No illicit drug use.

## Exam:

BMI 35.1. Antalgic gait. Hip ROM limited: flexion 94°, IR 8°, ER 24°. Leg length discrepancy 1.7 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Diabetes—coordinate with PCP to optimize HbA1c <8%. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 41

Patient Name: Margaret Lopez

Age/Sex: 56-year-old female

MRN: HR0041

Visit Date: 2025-07-01

Chief Complaint: Catching or locking in groin

## History of Present Illness (HPI):

Margaret Lopez describes a deep, aching pain in the groin, sometimes radiating toward the thigh, and it tends to tighten up if she sits too long. She says that if she sits to watch TV for a half hour, when she stands, the first dozen steps feel stiff until the hip loosens. Putting on socks or shoes has become difficult, sometimes needing help, which frustrates her independence. Conservative measures have included Tylenol (helpful briefly), meloxicam (takes the edge off), tramadol at night (causing grogginess), six weeks of PT (gained strength but pain persisted), cane use at times, and heat packs for temporary relief. Walking tolerance is about 700 feet before stopping. She has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

Hypertension, Blood clot, Obstructive sleep apnea

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.5 ppd × 20 yrs. No illicit drug use.

## Exam:

BMI 28.4. Antalgic gait. Hip ROM limited: flexion 95°, IR 9°, ER 18°. Leg length discrepancy 1.1 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed her imaging together and discussed the diagnosis along with possible treatment options. She is an appropriate candidate for total hip arthroplasty, and we will begin moving forward with pre-operative planning. Because she is an active smoker, I emphasized the importance of nicotine cessation for both surgical safety and recovery, and explained that cotinine testing will be required before surgery can proceed. She expressed understanding of these recommendations. We agreed to follow up in three weeks to reassess his progress and continue preparing for surgery.

# Chart 42

Patient Name: John Moore

Age/Sex: 68-year-old male

MRN: HR0042

Visit Date: 2025-08-27

Chief Complaint: Pain in the lateral thigh

## History of Present Illness (HPI):

John Moore reports hip pain for the past 41 weeks, and he admits it has begun to wear on him emotionally as much as physically. He describes the pain as a constant, heavy ache that grinds with every step, at times sharp enough to stop him in his tracks. By the end of the day the swelling makes him feel as though the joint is “burning from the inside out.” He says the crepitus when he moves is not just uncomfortable but “a reminder that something inside me is broken.” Climbing stairs feels like dragging himself up with sheer willpower, and rising from a chair often leaves him bracing, anxious for the stab of pain he knows is coming. He currently rates the pain as 9/10, and admits it leaves him exhausted and frustrated. Walking tolerance is only about 500 feet before he has to stop. He has tried Tylenol, meloxicam, tramadol, heat, and PT, but says none of it has given him lasting relief. He has not had prior hip injections. He denies systemic symptoms, has no cancer history, and no prior hip surgery.

While sharing his story, he kept circling back to Taylor Swift. He admitted that his hip pain hit him hardest during her concert—he couldn’t stay standing through the songs his granddaughter had been waiting months to hear, and he sat down feeling like he was letting her down. He laughed that his hip creaks along “like bad backup vocals,” but then grew quiet, admitting that it’s hard not to feel left behind, both at concerts and in daily life.

## Past Medical History:

Obstructive sleep apnea, Diabetes

## Past Surgical History:

Tonsillectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.1 ppd × 14 yrs. Occasional marijuana use.

## Exam:

BMI 40.7. Antalgic gait. Hip ROM limited: flexion 93°, IR 6°, ER 24°. Leg length discrepancy 1.2 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis as well as treatment options. With his BMI greater than 40, I recommended working toward at least a 10% weight reduction before moving forward with surgery. We also discussed the need to coordinate with his primary care physician to optimize his diabetes control and bring his HbA1c below 8%. As he is an active smoker, I counseled him on the importance of nicotine cessation, and explained that cotinine testing will be required prior to surgery. He understood the reasoning, though he admitted that tackling all these steps feels overwhelming—joking that it’s like trying to “get backstage at a Taylor Swift show, a lot of obstacles before you even see the stage.” We agreed to follow up in three weeks to reassess his progress and continue planning next steps.

# Chart 43

Patient Name: Dorothy Brown

Age/Sex: 64-year-old female

MRN: HR0043

Visit Date: 2025-06-10

Chief Complaint: Difficulty with bending down to put on shoes or socks

## History of Present Illness (HPI):

This is a 61-year-old female who has been struggling with hip pain for the past 25 weeks, though she admits it may have been present longer, with sharper worsening in the last couple of months. Dorothy Brown describes the pain as a deep, relentless ache in the groin, sometimes pulling down into the thigh, that feels like it steals more of her life each day. She explains that sitting for even a short time leaves her so stiff that standing up feels like trying to break free from a vise. She grows emotional describing how much she has lost—she can no longer play on the floor with her grandchildren, walk comfortably through the grocery store, or put on socks and shoes without help. She says even small routines, like standing at the stove to cook dinner or strolling around the block with her husband, now feel out of reach.

Conservative measures have included Tylenol (brief relief), meloxicam (helps somewhat but not enough), tramadol at night (offers rest but causes grogginess), six weeks of PT (strength improved but pain remained), cane use at times, and heat packs (temporary comfort). A corticosteroid injection 16 weeks ago gave about 60% relief, but only for 7 weeks. She denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain is currently 9/10 and exhausting, worsening to the point where she plans her day around it. Walking tolerance is about 600 feet before stopping. She tried swimming as an alternative, but the hip still tightened, leaving her discouraged.

As she spoke, Dorothy began to cry, saying she feels like her independence has been stripped away piece by piece. She mourns the things she once did without thinking—gardening, bending down to tie her shoes, dancing at her niece’s wedding—and fears she will keep losing more if nothing changes.

## Past Medical History:

GERD, Hyperlipidemia

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.6 ppd × 29 yrs. Remote cocaine use (no current use).

## Exam:

BMI 35.8. Antalgic gait. Hip ROM limited: flexion 90°, IR 7°, ER 19°. Leg length discrepancy 1.2 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed her imaging together and discussed the diagnosis along with treatment options. She is an appropriate candidate for total hip arthroplasty, and we will move forward with pre-operative planning. Because she is an active smoker, we talked about the importance of nicotine cessation for healing and recovery, and I explained that cotinine testing will be required before surgery. She grew emotional during this discussion, worried about whether she can manage these steps given how much the pain has already taken from her daily life. I reassured her that we will support her through the process and that each step is aimed at giving her the best chance at a safe and successful outcome. We agreed she will return in three weeks for reassessment and to continue preparing for surgery.

# Chart 44

Patient Name: William Williams

Age/Sex: 65-year-old male

MRN: HR0044

Visit Date: 2025-07-16

Chief Complaint: Hip stiffness

## History of Present Illness (HPI):

. He says that if he sits to watch Shark Tank for a half hour, when he stands, the first dozen steps feel stiff until the hip loosens. Putting on socks or shoes has become difficult, sometimes needing help, which frustrates his independence. Conservative measures have included Tylenol (helpful briefly), meloxicam (takes the edge off), tramadol at night (causing grogginess), six weeks of PT (gained strength but pain persisted), cane use at times, and heat packs for temporary relief. Corticosteroid injection 20 weeks ago with about 48% relief for 3 weeks. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 7/10, up to 8/10 on bad days. Walking tolerance is about 600 feet before stopping. He has tried swimming instead of walking, but feels overall things are slowly getting worse.

## Past Medical History:

Hypertension, Hyperlipidemia, GERD

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 0.4 ppd × 27 yrs. No illicit drug use.

## Exam:

BMI 31.5. Antalgic gait. Hip ROM limited: flexion 95°, IR 7°, ER 24°. Leg length discrepancy 1.9 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed his imaging together and discussed the diagnosis as well as the treatment options. He is an appropriate candidate for total hip arthroplasty, and we will begin moving forward with pre-operative planning. Because he is an active smoker, I explained the importance of stopping nicotine use for healing and recovery, and that cotinine testing will be required prior to surgery. He acknowledged the recommendations, and we agreed to follow up in three weeks to reassess progress and continue preparing for surgery.

# Chart 45

Patient Name: Michael Johnson

Age/Sex: 56-year-old male

MRN: HR0045

Visit Date: 2025-07-04

Chief Complaint: Catching or locking in groin

## History of Present Illness (HPI):

This is a 73-year-old male who has been struggling with hip pain for the past 75 weeks, though he admits it may have been present longer, with symptoms worsening in the last couple of months. He explains the pain not in medical terms but in the language of music—“a low, droning bass note in the groin that never quite stops,” sometimes joined by “a sharp, dissonant chord” radiating down into the thigh. After sitting too long, he says the first steps feel like “an out-of-tune piano—awkward, uneven, and jarring until it warms up.” On his worst days, he describes the pain as “a crescendo that builds and builds, no rest between measures.”

Conservative measures have included Tylenol (a brief diminuendo, quickly fading), meloxicam (takes the edge off but never resolves the dissonance), tramadol at night (helps him drift off but leaves him groggy in the morning, like a song played too slow), six weeks of PT (added strength but did not change the underlying melody of pain), cane use at times, and heat packs for temporary relief. A corticosteroid injection 9 weeks ago gave him “a short reprise,” about 70% relief for 3 weeks, but the pain returned like a persistent refrain. He denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain is currently 8/10, rising to the same on bad days. Walking tolerance is about 400 feet before stopping. Swimming has been attempted but “the rhythm of the stroke only made the hip join in with its own offbeat percussion,” and overall he feels things are slowly worsening.

He shared that music remains his refuge, though now he plays piano and guitar with the hip as an unwelcome accompanist. He laughs that every sour note is the hip’s fault, but admits the truth is harder—“the pain is always in the background, like a song I can’t turn off.”

## Past Medical History:

Diabetes, Smoking, Hyperlipidemia, Obstructive sleep apnea

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.1 ppd × 22 yrs. No illicit drug use.

## Exam:

BMI 41.3. Antalgic gait. Hip ROM limited: flexion 87°, IR 7°, ER 22°. Leg length discrepancy 1.7 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Recent injection <12 weeks; defer arthroplasty until safe interval passes. Diabetes—coordinate with PCP to optimize HbA1c <8%. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 46

Patient Name: Christopher Brown

Age/Sex: 74-year-old male

MRN: HR0046

Visit Date: 2025-07-05

Chief Complaint: Catching or locking in groin

## History of Present Illness (HPI):

Christopher Brown reports hip pain that has been worsening for many months. He describes it as a deep ache in the groin, sometimes spreading into the thigh, but says the harder part is what it represents. After sitting too long, standing feels like his hip is frozen, and those first dozen steps remind him that he’s no longer moving the way he once could. He admits it’s demoralizing—he used to pride himself on being quick on his feet, but now even putting on socks or shoes has become a slow, frustrating task that often requires help.

He has tried Tylenol (brief relief), meloxicam (dulls the pain but doesn’t free him), tramadol at night (allows some rest but leaves him groggy), six weeks of PT (strength improved but pain persisted), cane use at times, and heat packs with temporary comfort. He has not had prior hip injections. He denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain is currently 7/10, reaching 8/10 on harder days. Walking tolerance is about 600 feet before stopping. Swimming was attempted, but he felt even the water couldn’t take away the sense that his hip is holding him back.

As he told his story, Christopher reflected on his younger years, when he worked as a Chris Brown impersonator. He laughed at the memory of spinning and dancing at parties, but then grew quiet, admitting that now the thought of moving like that feels impossible. “Back then I could dance all night,” he said, “and now I’m lucky if I can make it across the room.” The pain, he explained, isn’t just physical—it’s a constant reminder of the distance between who he was and what he can do now.

## Past Medical History:

Hyperlipidemia, Hypertension

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.0 ppd × 35 yrs. Remote cocaine use (no current use).

## Exam:

BMI 37.3. Antalgic gait. Hip ROM limited: flexion 93°, IR 5°, ER 17°. Leg length discrepancy 1.3 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 47

Patient Name: Thomas Williams

Age/Sex: 83-year-old male

MRN: HR0047

Visit Date: 2025-06-24

Chief Complaint: Limping and pain

## History of Present Illness (HPI):

Thomas Williams describes a deep, aching pain in the groin, sometimes radiating toward the thigh, and it tends to tighten up if he sits too long. He says that if he sits to watch TV for a half hour, when he stands, the first dozen steps feel stiff until the hip loosens. Putting on socks or shoes has become difficult, sometimes needing help, which frustrates his independence. No prior hip injections. Denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain currently 6/10, up to 8/10 on bad days.

## Past Medical History:

Diabetes, Blood clot, Hypertension

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 22.0. Antalgic gait. Hip ROM limited: flexion 95°, IR 1°, ER 16°. Leg length discrepancy 1.3 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis as well as treatment options. He is an appropriate candidate for total hip arthroplasty, and we will move forward with pre-operative planning. Because of his diabetes, I recommended coordination with his primary care physician to optimize blood sugar control and bring his HbA1c below 8% before surgery. During our discussion, he became preoccupied with who would care for his cat while he recovers, voicing worry that this may be harder to arrange than the surgery itself. I reassured him that many patients make these kinds of practical plans ahead of time, and encouraged him to work with family or friends to set up support. We agreed to follow up in three weeks to reassess his progress and continue planning for surgery.

# Chart 48

Patient Name: Linda Lopez

Age/Sex: 79-year-old female

MRN: HR0048

Visit Date: 2025-07-04

Chief Complaint: Limping and pain

## History of Present Illness (HPI):

This is a 61-year-old female who has been struggling with hip pain for the past 26 weeks, though she admits it may have been there longer, with the past couple of months marking a clear worsening. Linda Lopez describes her pain not just as a symptom but as something that has seeped into every corner of her daily life. She says it feels like a deep, relentless ache in the groin, pulling down into the thigh, that doesn’t let her forget for a moment that something is wrong. Sitting too long turns the joint rigid, and when she stands, the first dozen steps feel heavy and clumsy, as though her body has forgotten how to move. What hurts most, she explains, isn’t the sharpness of the pain itself but the loss of ease—needing help with socks and shoes, stopping halfway across the room, watching her independence slip away.

She has tried Tylenol (brief relief), meloxicam (takes the edge off but never enough), tramadol at night (helps her sleep but leaves her groggy), six weeks of PT (gained strength but the pain persisted), cane use intermittently, and heat packs (comforting but short-lived). No prior hip injections. She denies fevers, chills, weight loss, cancer history, or prior hip surgery. Pain is currently 9/10, peaking to the same on bad days, with walking tolerance about 900 feet before she must stop. Swimming was attempted, but she says even in the water the hip finds a way to remind her of its presence, and she feels things are slowly worsening overall.

As she shared her story, Linda grew nostalgic about her years working in a chocolate factory. She recalled standing for hours on the production line, boxing sweets and sneaking the occasional piece when no one was watching. She laughed at how quickly she could move back then, darting between stations when a conveyor jammed, never once thinking about her joints. Now, she said, even the smell of chocolate makes her smile but also reminds her that those days of effortless motion are gone. She admitted, with a mix of humor and sadness, that if she tried to keep up with her old self in the factory today, she’d probably be left behind at the first conveyor belt..

## Past Medical History:

Hypertension, Blood clot

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.9 ppd × 10 yrs. No illicit drug use.

## Exam:

BMI 27.6. Antalgic gait. Hip ROM limited: flexion 87°, IR 0°, ER 23°. Leg length discrepancy 1.7 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed her imaging together and discussed the diagnosis as well as treatment options. She is an appropriate candidate for total hip arthroplasty, and we will move forward with pre-operative planning. Because she is an active smoker, I counseled her on the importance of stopping nicotine use for safe healing and recovery, and explained that cotinine testing will be required prior to surgery. She listened carefully and expressed determination, though she admitted the changes ahead feel daunting after how much the pain has already taken from her daily life. I reassured her that these steps are in place to protect her and to give her the best chance at a strong recovery. We agreed she will return in three weeks for reassessment and to continue preparing for surgery.

# Chart 49

Patient Name: Dorothy Martinez

Age/Sex: 65-year-old female

MRN: HR0049

Visit Date: 2025-07-24

Chief Complaint: Hip stiffness

## History of Present Illness (HPI):

Dorothy Martinez reports hip pain for 28 weeks with crepitus with hip motion, aching worsened by activity and improved with rest, stiffness after inactivity, worse in mornings. Pain 7/10. Walk tolerance ~900 ft. Tried Tylenol, meloxicam, tramadol, heat, PT. Corticosteroid injection 19 weeks ago with about 75% relief for 7 weeks. Denies systemic symptoms, no cancer history, no prior hip surgery.

## Past Medical History:

Hypertension, Diabetes, Blood clot

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 25.4. Antalgic gait. Hip ROM limited: flexion 95°, IR 0°, ER 23°. Leg length discrepancy 1.8 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, no cystic change. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total hip arthroplasty; proceed with pre-op planning. Diabetes—coordinate with PCP to optimize HbA1c <8%. Return in 3 weeks for reassessment.

# Chart 50

Patient Name: John Johnson

Age/Sex: 65-year-old male

MRN: HR0050

Visit Date: 2025-08-11

Chief Complaint: Catching or locking in groin

## History of Present Illness (HPI):

John Johnson reports hip pain for the past 72 weeks, describing stiffness after inactivity that is worse in the mornings, along with progressive difficulty walking, climbing stairs, and rising from a seated position. He also experiences swelling and increased pain by the end of the day. Current pain is 8/10. Walking tolerance is about 900 feet before needing to stop. He has tried Tylenol (brief relief), meloxicam (helps somewhat), tramadol (improves pain but causes grogginess), heat, and physical therapy. A corticosteroid injection 15 weeks ago provided about 65% relief, though only for 7 weeks. He denies systemic symptoms, has no cancer history, and no prior hip surgery.

John shared that the pain has been especially discouraging because he owns and operates a taco truck. He laughed about how customers think he’s “just moving slow because the tacos are made fresh,” when in reality his hip is stiff and throbbing after standing inside the truck all day. He described the struggle of climbing in and out of the vehicle, saying it feels like “scaling a mountain” just to get behind the grill. He admits that by the time the lunch rush is over, his hip is swollen and aching, though he tries to hide it with jokes while handing out tacos. He worries that if the pain keeps worsening, he won’t be able to keep up with the demands of the business he built from scratch.

## Past Medical History:

Smoking, Diabetes, GERD, Obstructive sleep apnea

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.0 ppd × 18 yrs. No illicit drug use.

## Exam:

BMI 45.1. Antalgic gait. Hip ROM limited: flexion 85°, IR 0°, ER 27°. Leg length discrepancy 1.2 cm. Pain with log roll. Knee ROM normal. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

AP pelvis and lateral hip X-rays show severe joint space narrowing, osteophyte formation, subchondral sclerosis, subchondral cystic change present. No fracture.

## Assessment:

Hip osteoarthritis with progressive pain and functional limitation despite conservative care.

## Plan:

We reviewed imaging and treatment options. He’s a candidate for total hip arthroplasty; will start pre-op planning. BMI >40 → advised at least 10% weight loss. Diabetes → coordinate with PCP to optimize HbA1c <8%. Active smoker → counseled cessation; cotinine test required. He joked this will be harder than cutting tortillas out of the taco truck menu. Follow up in 3 weeks.