The Arthroplasty Foundation

Donald L. Pomeroy, M.D.

HOOS EVALUATION

Date of Evaluation

DD-MMM-YYYY

Subject ID #

Subject Name/Initials

Last Name, first name or FML initial

Date of Birth

Side: ☐ Right ☐ Left ☐ Both

INSTRUCTIONS: This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities. Answer every question as indicated by marking **(X)** in the appropriate box. Mark **ONLY ONE** box for **EACH** question. If you are uncertain about how to answer a question, please give the **BEST** answer you can.

SYMPTOMS: These questions should be answered thinking of your **hip symptoms and difficulties** during the **last week**.

S1. Do you feel grinding, hear clicking or any other type of noise from your hip?

Right:	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
Left:	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always

S2. Difficulties spreading legs wide apart?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

S3. Difficulties to stride out when walking?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

STIFFNESS: The following questions concern the amount of joint stiffness you have experienced during the **last week** in your hip. Stiffness is a sensation of restriction or slowness in the ease with which you move your hip joint.

S4. How severe is your hip joint stiffness after first wakening in the first morning?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

S5. How severe is your hip stiffness after sitting, lying or resting **later in the day**?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

PAIN:

P1. How often is your hip painful?

Right:	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always
Left:	☐ Never	☐ Rarely	☐ Sometimes	☐ Often	☐ Always

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

P2. Straightening your hip fully?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

P3. Bending your hip fully?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

P4. Walking on a flat surface?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

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

P5. Going up or down stairs?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
P6. At night in bed?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
P7. Sitting or lying?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
P8. Standing upright?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
P9. Walking on a hard surface (asphalt, concrete, etc.)?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
P10. Walking on an uneven surface?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

FUNCTION, DAILY LIVING: The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

A1. Descending stairs?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A2. Ascending stairs?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A3. Rising from sitting?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A4. Standing?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A5. Bending to floor/picking up an object?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

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				☐ Right ☐ Left ☐ Both

FUNCTION, CONTINUED: For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

A6. Walking on a flat surface?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A7. Getting out of the car?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A8. Going shopping?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A9. Putting on socks/stockings?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A10. Rising from bed?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A11. Taking off socks/stockings?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A12. Lying in bed (turning over, maintaining hip position)?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A13. Getting in/out of the bath?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A14. Sitting?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A15. Getting on/off of the toilet?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, etc.)?					
Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

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FUNCTION, CONTINUED: For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

A17. Light domestic duties (cooking, dusting, etc.)?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

FUNCTION, SPORTS, AND RECREATIONAL ACTIVITIES: The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your hip.

SP1. Squatting?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

SP2. Running?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

SP3. Twisting/pivoting on loaded leg?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

SP4. Walking on an uneven surface?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme

QUALITY OF LIFE:

Q1. How often are you aware of your hip problem?

Right:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily	☐ Constantly
Left:	☐ Never	☐ Monthly	☐ Weekly	☐ Daily	☐ Constantly

Q2. Have you modified your lifestyle to avoid activities potentially damaging to your hip?

Right:	☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely	☐ Totally
Left:	☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely	☐ Totally

Q3. How much are you troubled with lack of confidence in your hip?

Right:	☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely	☐ Extremely
Left:	☐ Not at all	☐ Mildly	☐ Moderately	☐ Severely	☐ Extremely

Q4. In general, how much difficulty do you have with your hip?

Right:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme
Left:	☐ None	☐ Mild	☐ Moderate	☐ Severe	☐ Extreme