

DR. WEBER HIP INFORMATION SHEET

Name: _____ DOB: _____ Date: _____

In order to make your evaluation and treatment more efficient, we would appreciate you completing this questionnaire as accurately as possible. Please check off all appropriate answers.

1. Do you have:

Groin Pain	Yes _____	No _____
Buttock Pain	Yes _____	No _____
Below Knee Pain	Yes _____	No _____
Night Pain	Yes _____	No _____
Pain Walking	Yes _____	No _____
Pain at Side of Hip	Yes _____	No _____

2. Did you have an injury? Yes _____ No _____,
or has the pain come on gradually? Yes _____ No _____

3. Do you have weakness _____, numbness _____, or tingling _____ in the legs?

4. Do your legs become tired when you walk causing you to sit down to relieve the tiredness? Yes _____ No _____

5. Do you take medication for your hip pain? Yes _____ No _____

6. If you take medication for your hip pain:
Name of pill: _____? Strength: _____ mgs,
How many? _____ How often? _____ hrs.

7. Do you use a cane _____, walker _____, or wheel chair _____?

8. Have you had physical therapy? Yes _____ No _____
If yes, where? _____
If yes, for how long? _____ weeks _____ months
If yes, has it helped? Yes _____ No _____
If yes, are you still going? Yes _____ No _____

9. Have you ever had an operation on your hip? Yes _____ No _____

10. Have you had:

Hip X-ray	Yes _____	No _____
Hip MRI	Yes _____	No _____