

DR. AMEYA KATARIYA

DNB, Dip. Orth, MBBS

Fellowship trained Hip and
Knee Orthopaedic Surgeon

PATIENT HIP HISTORY FORM

Name: _____

Date of Birth: _____

Which Hip: Left Right Both

Chief Complaint: _____

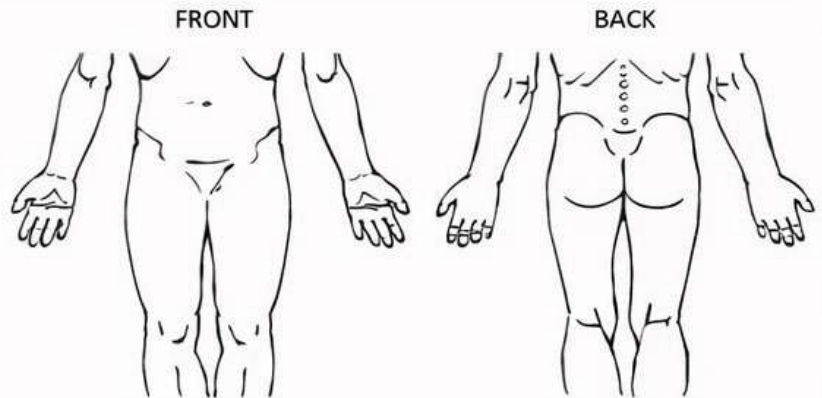
Problems With Your Hip: Pain Stiffness Other _____

Location of Pain: Groin Lateral (Side) Other _____

When Did Your Problems Start: _____

How Did It Start (ie. Fall/Injury/Sport/Work): _____

Where Do You Have Pain About The Hip?
(Please Indicate on Diagram)



Does Any Position/Activity Make the Pain Better/Worse: _____

Do You Have Hip Pain At Night: _____

Sitting to Standing: Yes No Getting Out of Car: Yes No

Do You Feel One Leg is Longer Than the Other: Yes No _____

Do You Have Problems / Pain with Stairs: _____

Do You Have Any Current or History of Lower Back Pain: _____

What Treatment(s) Have You Had So Far: _____

How Far/Long Can You Walk Before the Pain Stops You (ie 300m/30min): _____

Previous Problems or Surgery With Your Hip: _____

What Activities Do You Want To Return To: _____

Medical Conditions & Previous Surgeries: _____

Do You Have a History of Blood Clots, Clotting Disorders or Bleeding Disorders: _____

Medications / Allergies: _____