COFFEE REGIONAL MEDICAL CENTER

Pre−Surgery Patient−Reported Functional Assessment
HIP
As per AAOS PROMs

2NN

Check one answer per row	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is:					
In general, would you say your quality of life is:					
In general, how would you rate your physical health?					
In general, how would you rate your mental health, including your mood and your ability to think?					
In general, how would you rate your satisfaction with your social activities and relationships?					
In general, how well you carry out your usual social activities and roles? (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)					

Check one answer per row	Completely	Mostly	Moderately	A Little	Not at all
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?					

Check one answer per row (In the past 7 days)	Never	Rarely	Sometimes	Often	Always
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?					

Check one answer per row (In the past 7 days)	None	Mild	Moderate	Severe	Very Severe
How would you rate your fatigue on average?					

How would you rate your pain on average? (Circle one) 0=No pain; 1 = Mild Pain; 10 = Worst Imaginable Pain	0	1	2	3	4	5	6	7	8	9	10

Check one answer per row (In the past 7 days)	Not at all	A little bit	Somewhat	Quite a bit	Very Severe
How much did pain interfere with your day to day activities?					
How much did pain interfere with work around the home?					
How much did pain interfere with your ability to participate in social activities?					
How much did pain interfere with your enjoyment of life?					
How much did pain interfere with the things you usually do for fun?					
How much did pain interfere with your enjoyment of social activities?					
How much did pain interfere with your household chores?					
How much did pain interfere with your family life?					

Signature of RN Noting Assessment:	Time:	Date:

NN_8139_EFR
Rev 04/26/24

What amount of pain have you experienced in the last week in your other knee/hip (in the knee/hip not being treated?)

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑	Not Applocable ❑

My back pain at the moment is...

None ❑	Very Mild ❑	Moderate ❑	Fairly Severe ❑	Very Severe ❑	Worst Imaginable ❑	Not Applocable ❑

How comfortable are you filling out medical forms by yourself?

Not at all ❑	A little bit ❑	Somewhat ❑	Quite a bit ❑	Extremely ❑	Not Applocable ❑

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 by ticking the appropriate box. Only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Pain

What ammount of hip pain have you experenced the last week during the following activities?

1. Going up or down stairs

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑

2. Walking on uneven surfaces

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑

Function, daily living: The following questions concern your physicial 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 experenced in the **last week** due to your hip.

3. Rising from sitting

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑

4. Bending to floor/pick up an object

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑

5. Lying in bed (turning over, maintaining hip position)

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑

6. Sitting

None ❑	Mild ❑	Moderate ❑	Severe ❑	Extreme ❑