HOOS, JR.
HIP SURVEY

PATIENT _____

DATE _____

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 checking the appropriate box, ***only one box for each question***. If you are unsure, just give the best answer possible.

PAIN

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

1. GOING UP OR DOWN STAIRS

None	Mild	Moderate	Severe	Extreme
○	○	○	○	○

2. WALKING ON AN UNEVEN SURFACE

None	Mild	Moderate	Severe	Extreme
○	○	○	○	○

FUNCTION, DAILY LIVING

The following questions concern your physical function or 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.

3. RISING FROM SITTING

None	Mild	Moderate	Severe	Extreme
○	○	○	○	○

4. BENDING TO FLOOR/PICKING 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
○	○	○	○	○