

HOOS, JR. HIP SURVEY

INSTRUCTIONS: This questionnaire 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. Please respond to ALL questions. For questions related to activities that you choose to avoid, cannot perform, or have been instructed by a medical professional to avoid, please select the response of "Extreme."

Pain

What amount of hip pain have you experienced 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. 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.

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