PATIENT REPORTED OUTCOME MEASURES

PATIENT LABEL

❑ Left

❑ Right

HIP

HOOS-JR

PAIN - What amount of hip pain have you experienced the last week during the following activities?

	NONE	MILD	MODERATE	SEVERE	EXTREME
1. Going up or down stairs	❑	❑	❑	❑	❑
2. Walking on an uneven surface	❑	❑	❑	❑	❑

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	❑	❑	❑	❑	❑
4. Bending to floor/pick up an object	❑	❑	❑	❑	❑
5. Lying in bed (turning over, maintaining hip position)	❑	❑	❑	❑	❑
6. Sitting	❑	❑	❑	❑	❑

PROMIS-10 GLOBAL

Please respond to each item by marking one box per row.

	EXCELLENT	VERY GOOD	GOOD	FAIR	POOR
1. In general, would you say your health is:	❑	❑	❑	❑	❑
2. In general, would you say your quality of life is:	❑	❑	❑	❑	❑
3. In general, how would you rate your physical health?	❑	❑	❑	❑	❑
4. In general, how would you rate your mental health, including your mood and your ability to think?	❑	❑	❑	❑	❑
5. In general, how would you rate your satisfaction with your social activities and relationships?	❑	❑	❑	❑	❑
6. In general, please rate 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.)	❑	❑	❑	❑	❑

	COMPLETELY	MOSTLY	MODERATELY	A LITTLE	NOT AT ALL
7. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	❑	❑	❑	❑	❑

Please respond to each item by marking one box per row.

In the past 7 days.....	NEVER	RARELY	SOMETIMES	OFTEN	ALWAYS
8. How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	❑	❑	❑	❑	❑

Please complete the front and back of this form

PROMIS-10 GLOBAL (Con't)

	NONE	MILD			MODERATE			SEVERE		VERY SEVERE
9. How would you rate your fatigue on average?	❑	❑			❑			❑		❑

	NO PAIN										WORST IMAGINABLE PAIN
	0	1	2	3	4	5	6	7	8	9	10
10. How would you rate your pain on average?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

OPIOID USE

Please mark the box that best represents your answer, giving only one answer. If you are unsure how to answer a question, please give the best answer you can.

	YES	NO
1. Do you take opioid pain medications every day or most days (e.g. hydrocodone, Norco, Vicodin, oxycodone, morphine, codeine, etc.)?	❑ (if YES, please continue to the next question)	❑ (if NO, please skip the next question)

	Operative Joint Pain	Other pain in different area of your body	Operative Joint Pain AND other pain in different area of your body	Other reason, not for pain
2. Why do you take this opioid pain medication(s)?:	❑	❑	❑	❑

CMS ADDITIONAL QUESTIONS

Please mark the box that best represents your answer, giving only one answer. If you are unsure how to answer a question, please give the best answer you can.

	NONE	MILD	MODERATE	SEVERE	EXTREME
1. What amount of pain have you experienced in the last week in your other hip?	❑	❑	❑	❑	❑

	NONE	VERY MILD	MODERATE	FAIRLY SEVERE	VERY SEVERE	WORST IMAGINABLE
2. My BACK PAIN at the moment is:	❑	❑	❑	❑	❑	❑

	EXTREMELY	QUITE A BIT	SOMEWHAT	A LITTLE BIT	NOT AT ALL
3. How comfortable are you filling out medical forms by yourself?	❑	❑	❑	❑	❑

PATIENT SATISFACTION QUESTION

AFTER SURGERY ONLY - Please skip this question if your surgery has not yet occurred

Please mark the box that best represents your answer, giving only one answer. If you are unsure how to answer a question, please give the best answer you can.

	VERY SATISFIED	SATISFIED	NEUTRAL	DISSATISFIED	VERY DISSATISFIED
1. How satisfied are you with the results of your [right/left] hip replacement (so far)?	❑	❑	❑	❑	❑

Thank you! - Please return this form to a medical team member

FOR ADMINISTRATIVE USE ONLY

NOTATION	DATE COLLECTED	DATE OF SURGERY	PROCEDURE
			(L) (R) - HIP

COLLECTION INTERVAL

❑ PRE-OP ❑ 2-16 WEEKS ❑ 4-6 MONTHS ❑ 1 YEAR ❑ _____

RETURN THIS DOCUMENT TO:

NAME CONTACT

V3.2025.11.03.JB