



DR. ECCLES HIP QUESTIONNAIRE

Name: _____ Age: _____ Right ^{circle} Left

1. Duration of pain: ___ months ___ years
2. Location of pain: Groin Outside (lateral) Thigh Buttocks Other: _____
3. What activities make your hip pain worse:
 Stairs Walking long distances Socks/shoes Lying on side Other: _____
4. Have you tried formal physical therapy or a self-directed exercise program? YES NO
5. Prior medication treatments you have tried:

Narcotics (tramadol/hydrocodone/oxycodone):	YES	NO
NSAIDs (ibuprofen/Celebrex/naproxen/Aleve/meloxicam):	YES	NO
Tylenol (acetaminophen):	YES	NO
6. Have you ever had an injection in the hip? YES NO
 If so, when was the last time? _____
7. Have you ever had previous surgery on this hip? YES NO
 If so, when and what was done? _____
8. Do you have diabetes? YES NO
 If so, what was your last A1c? _____
9. Do you smoke or use any nicotine? YES NO
10. Have you ever had a bad surgical infection (ex. MRSA)? YES NO
11. Who do you live with? _____
12. What other medical problems do you have? _____