OXFORD HIP SCORE

Name:

Dates of past HIP surgery.

Right Hip
Left Hip

DOB: MRN NO:

Height. Weight.

Date: **Dr Z Szomor**

This is an assessment for : (Tick)

Left Hip
Right Hip:
Both Hips:

BASE YOUR ANSWERS ON HOW YOUR HIPS HAVE FELT OVER THE LAST 4 WEEKS.

Please tick one box for every question for your left and right hip.

		Left	Right
During the past 4 weeks ….. 1. How would you describe the pain you **usually** have from your hip ?	Severe		
	Moderate		
	Mild		
	Very mild		
	None		
		Left	Right
During the past 4 weeks ….. 2. Have you had any trouble with washing and drying yourself (all over) **because of your hip** ?	Impossible to do		
	Extreme difficulty		
	Moderate trouble		
	Very little trouble		
	No trouble at all		
		Left	Right
During the past 4 weeks ….. 3. Have you had any trouble getting in and out of a car or using public transport **because of your hip** ? (whichever you would tend to use)	Impossible to do		
	Extreme difficulty		
	Moderate trouble		
	Very little difficulty		
	No trouble at all		
		Left	Right
During the past 4 weeks … 4. Have you been able to put on a pair of socks, stockings or tights ?	No, impossible		
	With extreme difficulty		
	With moderate difficulty		
	With little difficulty		
	Yes, easily		
		Left	Right
During the past 4 weeks …. 5. could you do the household shopping **on your own** ?	No, impossible		
	With extreme difficulty		
	With moderate difficulty		
	With little difficulty		
	Yes, easily		
		Left	Right
During the past 4 weeks … 6. for how long have you been able to walk before **the pain from your hip** becomes severe (with or without a stick)	Not at all – pain severe on walking		
	Around the house only		
	5-15 minutes		
	16 – 30 minutes		
	No pain/more than 30 minutes		

During the past 4 weeks ….. 7. have you been able to climb a flight of stairs ?			
	No, impossible		
	With extreme difficulty		
	With moderate difficulty		
	With little difficulty		
	Yes, easily		
		Left	Right

During the past 4 weeks ….. 8. after a meal (sat at a table) how painful has it been for you to stand up from a chair **because of your hip** ?			
	Unbearable		
	Very painful		
	Moderately painful		
	Slightly painful		
	Not at all painful		
		Left	Right

During the past 4 weeks ….. 9. have you been limping when walking **because of your hip** ?			
	All the time		
	Most of the time		
	Often, not just at first		
	Sometimes, or just at first		
	Rarely/never		
		Left	Right

During the past 4 weeks … 10. have you had any sudden or severe pain - Shooting, stabbing or spasms **from the affected hip** ?			
	All of the time		
	Most of the time		
	Often, not just at first		
	Sometimes or just at first		
	Rarely/never		
		Left	Right

During the past 4 weeks …. 11. how much pain **from your hip** interfered With your usual work ? (including housework)			
	Totally		
	Greatly		
	Moderately		
	A little bit		
	Not at all		
		Left	Right

During the past 4 weeks … 12. have you been troubled **by pain from your hip** in bed at night ?			
	Every night		
	Most nights		
	Some nights		
	One 1 or 2 nights		
	No nights		

Do you take anti-inflammatory medication ?	Circle	***Never. Sometimes. Regularly***
Do you take non prescribed analgesia ?	Circle	Never. Sometimes. Regularly
Do you take prescription analgesia ?	Circle	Never. Sometimes. Regularly
Do you use walking aids ?	Circle	Never. Sometimes. Regularly
If so – what devices. 1 cane. 2 canes. Crutches. Walking frame	Circle	

Left hip total.	Right hip total.

Have you any other pain / condition that affects your mobility	If so explain	
What is the level of your satisfaction (Tick your answer for each hip)	<u>Left hip</u> Very satisfied	<u>Right hip</u> Very satisfied
	Satisfied	Satisfied
	Uncertain	Uncertain
	Unsatisfied	Unsatisfied