HOOS Hip Survey Hip Dysfunction and Osteoarthritis Outcome Score

Name _____ Date_____

Instructions: Please circle the response that best describes your symptoms/stiffness/pain performing specific activities during the past week. Please answer all questions.

	Never	Rarely	Sometimes	Often	Always
Do you feel grinding; hear clicking or any other type of noise from your hip?	0	1	2	3	4

	None	Mild	Moderate	Severe	Extreme
Difficulties spreading legs wide apart	0	1	2	3	4
Difficulties to stride out when walking	0	1	2	3	4
How severe is the hip stiffness after first awakening in the morning?	0	1	2	3	4
How severe is the hip stiffness after sitting, lying, or resting later in the day?	0	1	2	3	4

	Never	Monthly	Weekly	Daily	Always
How often is your hip painful?	0	1	2	3	4

What degree of <u>pain</u> have you experienced in the past week when…?

	None	Mild	Moderate	Severe	Extreme
Straightening your hip fully	0	1	2	3	4
Bending your hip fully	0	1	2	3	4
Walking on flat surfaces	0	1	2	3	4
Going up or down stairs	0	1	2	3	4
At night while in bed	0	1	2	3	4
Sitting or lying	0	1	2	3	4
Standing upright	0	1	2	3	4
Walking on a hard surface (i.e. concrete)	0	1	2	3	4
Walking on an uneven surface	0	1	2	3	4

What degree of <u>difficulty</u> have you experienced in the past week when…?

	None	Mild	Moderate	Severe	Extreme
Descending stairs	0	1	2	3	4
Ascending stairs	0	1	2	3	4
Rising from sitting	0	1	2	3	4
Standing	0	1	2	3	4
Bending to floor/picking up an object	0	1	2	3	4

Walking on flat surface	0	1	2	3	4
Getting in/out of a car	0	1	2	3	4
Going shopping	0	1	2	3	4
Putting on socks/stockings	0	1	2	3	4
Rising from bed	0	1	2	3	4
Taking off socks/stockings	0	1	2	3	4
Lying in bed (turning over, maintaining hip position)	0	1	2	3	4
Getting in/out of the bath/shower	0	1	2	3	4
Sitting	0	1	2	3	4
Getting on/off toilet	0	1	2	3	4
Heavy domestic duties (Moving boxes, scrubbing floors, etc.)	0	1	2	3	4
Light domestic duties (cooking, dusting, etc.)	0	1	2	3	4

Sports Related Activities: What difficulty levels have you experienced in the past week when…?

	None	Mild	Moderate	Severe	Extreme
Squatting	0	1	2	3	4
Running	0	1	2	3	4
Twisting/Pivoting on loaded leg	0	1	2	3	4
Walking on an uneven surface	0	1	2	3	4

Hip Related Quality of Life

	Never	Monthly	Moderately	Weekly	Constantly
How often are you aware of your hip problem?	0	1	2	3	4
	Not at all	**Mildly**	**Moderately**	**Severely**	**Totally**
Have you modified your lifestyle to avoid potentially damaging activities to your hip?	0	1	2	3	4
How troubled are you with lack of confidence in your hip?	0	1	2	3	4
	None	**Mild**	**Moderate**	**Severe**	**Extreme**
In general, how much difficulty do you have with your hip?	0	1	2	3	4