MINNEAPOLIS ORTHOPAEDICS

Advanced skills and experience for the results you deserve

PATIENT INFORMATION SHEET

Hip

Right Left

Name: _____

Date:_____

Please give a brief description of your symptoms/problems (When and how does it hurt)

_____

_____

_____

When did this start?

(approximate date or number of days, weeks, months, years)

_____

History of Injury?

_____

How does your hip hurt? (Circle which one applies)

Inside Outside Front Back

Have you had any surgery on your hip?

Yes No When?_____

Type of operation, if known_____

Have you had any of these examinations done to your hip?

X-rays?	**Where?**_____	**When?**_____
Arthrogram?	**Where?**_____	**When?**_____
CT?	**Where?**_____	**When?**_____
Ultrasound?	**Where?**_____	**When?**_____
MRI?	**Where?**_____	**When?**_____