

PRE-OP

Complete these questionnaires/surveys and return them to the Joint & Spine Center **BEFORE** your surgery date. There is a designated area on the form for you to include your name, date of birth, your surgeon's name, date of surgery, and which hip underwent a joint replacement.

Greater Baltimore Medical Center
Joint and Spine Center, office 5835
6701 North Charles Street
Towson, MD 21204

Complete this questionnaire only if you do not have an e-mail address. Please mail it back to: GBMC's Joint & Spine Center

HOOS, JR. HIP SURVEY

Pre-op

INSTRUCTIONS: This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities. Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Pain

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

- 1. Going up or downstairs

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 2. Walking on an uneven surface

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 4. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 5. Lying in bed (turning over, maintaining hip position)

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 6. Sitting

None	Mild	Moderate	Severe	Extreme
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: _____ **Date of Birth:** ___/___/___ **Surgeon's Name** _____

Date of Surgery: ___/___/___ **Right, Left, or Bilateral Hip?** _____ **Today's Date** ___/___/___

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GBMC's Joint & Spine Center

Self-Administered
OMB ###-####

Today's Date ___/___/___

Patient Name: _____

Date of Birth: ___/___/___

Surgeon Name: _____

Date of Surgery: ___/___/___

Knee or Hip? _____ Right (R), Left (L), or Bilateral (B)? _____

THE VETERANS RAND 12-ITEM HEALTH SURVEY (VR-12)

The following questions ask for your views about your health—how you feel and how well you are able to do your usual activities. All kinds of people across the country are being asked these same questions. Their answers and yours will help to improve health care for everyone. There are no right or wrong answers; please choose the answer that best fits your life right now.

Answer each question by marking an 'X' next to the best response. For example:

What is your gender?

- Male
 Female

Q1. In general, would you say your health is:

- Excellent
 Very good
 Good
 Fair
 Poor

Q2. The following questions are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

a. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?

- Yes, limited a lot
 Yes, limited a little
 No, not limited at all

b. Climbing **several** flights of stairs?

- Yes, limited a lot
 Yes, limited a little
 No, not limited at all

Public reporting burden for this collection of information is estimated to average 7 minutes per response. This time includes the length of time allotted for the survey questions. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Address, ATTN; PRA (XXX-XXXX). Do not return the completed form to this address.

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Self-Administered

Q3. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

a. Accomplished **less** than you would like.

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

b. Were limited in the **kind** of work or other activities.

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

Q4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

a. **Accomplished less** than you would like.

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

b. Didn't do work or other activities as **carefully** as usual.

- No, none of the time
- Yes, a little of the time
- Yes, some of the time
- Yes, most of the time
- Yes, all of the time

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Q5. During the past 4 weeks, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

Q6a. How much of the time during the past 4 weeks:

Have you felt calm and peaceful?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

Q6b. How much of the time during the past 4 weeks:

Did you have a lot of energy?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

Q6c. How much of the time during the past 4 weeks:

Have you felt downhearted and blue?

- All of the time
- Most of the time
- A good bit of the time
- Some of the time
- A little of the time
- None of the time

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Q7. During the past 4 weeks, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

Now, we'd like to ask you some questions about how your health may have changed.

Q8. Compared to one year ago, how would you rate your **physical health** in general now?

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse

Q9. Compared to one year ago, how would you rate your **emotional problems** (such as feeling anxious, depressed or irritable) **now**?

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse

Your answers are important!

Thank you for completing this questionnaire!

The items in this questionnaire were obtained from the Medicare Health Outcomes Survey (HOS) with the express permission of NCQA and the Centers for Medicare & Medicaid Services (CMS). However, this survey is not being used as part of the Medicare HOS program and is not recognized as such by NCQA or CMS.

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Items 1-9: The VR-12 Health Survey item content was developed and modified from a 36-item health survey.

This survey was developed at RAND as part of the Medical Outcomes Study.
It was developed with support from the US Department of Veterans Affairs.

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