PRE-OP

Complete these questionnaires/surveys and return them to the Joint & Spine Center BEFORE your surgery date. Theres 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 down stairs

None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

2. Walking on an uneven surface

None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

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 ☐

4. Bending to floor/pick up an object

None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

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

None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

6. Sitting

None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐

Patient Name:_____Date of Birth: ___/___/____Surgeon's Name_____

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

Pre-Op

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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

Pre-Op

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

Date of surgery: _____

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!