B E C K E R
O R T H O P E D I C S
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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?_____