LewisGale Physicians
HCA Virginia Health System
An HCA affiliate

Date: _____

Patient Name: _____ DOB: _____

Patient Medical History for HIP Symptoms

Referred by: _____ Date of Injury/Onset of Symptoms: _____

Reason for visit: Describe injury or onset in detail: ☐**Left** ☐**Right**

_____

_____

_____

Pain: ☐Sharp ☐Dull ☐Stabbing ☐Burning ☐Other: _____

Pain: ☐ Constant ☐Intermittent

Pain Intensity (circle): 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

0 – No Pain
1 – Mild Pain, you are aware of the pain, but it does not bother you
2 – Moderate Pain – You can tolerate pain without medication
3 – Moderate Pain – Requires Medication to tolerate pain
4 – 5 – More Severe Pain – you begin to feel anti-social
6 – Severe Pain
7 – 9 - Intensely Severe Pain
10 – Most Severe Pain, Emergency Room Care

Location (describe): _____

_____

Does the Pain go anywhere else (describe)? _____

_____

What makes the pain worse? ☐Standing ☐Walking ☐Running ☐Stairs ☐Squatting ☐Pivoting ☐Sitting ☐Lying On Side ☐Other? _____

What makes pain Better? ☐Rest ☐Activity Modification ☐Ice/Heat ☐Meds ☐Brace ☐Other: _____

What other symptoms are present? ☐Catching ☐Popping ☐Grinding ☐Locking ☐Giving Way ☐Back Pain ☐Numbness/Tingling

Have you received an injection in your current problem area? ☐NO ☐YES If YES, when? _____

What treatments have you attempted and what effect (PT, Meds, Injections**)?** _____

_____

_____

Can you work or participate in sports with current symptoms? ☐NO ☐YES

Do you have light duty available at work? ☐NO ☐YES