

To reproduce, follow the printing instructions.

Fold only on the dotted lines.

Oxford Hip

Please answer every question

Compatible Note forms:
Oxford Hip Score – LEFT HIP
Oxford Hip Score – RIGHT HIP

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PATIENT'S FIRST NAME

MIDDLE INITIAL

PATIENT'S DATE OF BIRTH

Month Day Year

On which side of your body is the affected hip for which you are receiving treatment? (please choose one)

Left

Right

If BOTH hips are affected, please complete the first questionnaire thinking about the right side.
You will then fill out a second questionnaire for the left side.

During the past 4 weeks...

How would you describe the pain you usually have from your hip?

None

Mild

Severe

Very mild

Moderate

----- please fold on dotted line -----

Have you had any trouble with washing and drying yourself (all over) because of your hip?

No trouble at all

Moderate trouble

Impossible to do

Very little trouble

Extreme difficulty

Have you had any trouble getting in and out of a car or using public transport because of your hip? (whichever you tend to use)

No trouble at all

Moderate trouble

Impossible to do

Very little trouble

Extreme difficulty

Have you been able to put on a pair of socks, stockings or tights?

Yes, easily

With moderate difficulty

No, impossible

With little difficulty

With extreme difficulty

Could you do the household shopping on your own?

Yes, easily

With moderate difficulty

No, impossible

With little difficulty

With extreme difficulty

For how long have you been able to walk before pain from your hip becomes severe? (with or without a stick)

No pain/More than 30 minutes

5 to 15 minutes

Not at all/pain severe when walking

16 to 30 minutes

Around the house only

Have you been able to climb a flight of stairs?

Yes, easily

With moderate difficulty

No, impossible

With little difficulty

With extreme difficulty

After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your hip?

Not at all painful

Moderately painful

Unbearable

Slightly painful

Very painful

----- please fold on dotted line -----

Have you been limping when walking, because of your hip?

Rarely/never

Often, not just at first

All of the time

Sometimes, or just at first

Most of the time

Have you had any sudden, severe pain - 'shooting', 'stabbing' or 'spasms' - from the affected hip?

No days

Some days

Every day

Only 1 or 2 days

Most days

How much has pain from your hip interfered with your usual work (including housework)?

Not at all

Moderately

Totally

A little bit

Greatly

Have you been troubled by pain from your hip in bed at night?

No nights

Some nights

Every night

Only 1 or 2 nights

Most nights

Finally, please check back that you have answered each question.

Thank you very much.