HIP ARTHROSCOPY:
Labral Reconstruction
DR. BRIAN J. WHITE

Initial Patient Evaluation Form

Brian J. White M.D.
Orthopaedic Surgeon – Specialist in
Disorders of the Hip

WESTERN ORTHOPAEDICS

NAME: _____

Age: _____ **Today's Date:** _____

Date of Birth: _____ **Marital Status:** _____

Occupation/Job: _____

Did another doctor send you to us? ○Yes ○No
If yes, please give name and address of physician:
_____
_____
_____

Where is your problem? (please select)

○ **Right Hip** ○ **Left Hip**

○ **Lower Back** ○ **Buttock**

Problems (please check all that apply)

- ☐ Pain?
- ☐ Weakness?
- ☐ Instability/Giving way/Dislocation?
- ☐ Stiffness?
- ☐ Swelling?
- ☐ Other? _____

How did you injure yourself?

- ☐ No injury, just started hurting
- ☐ Sports (which sport?)_____
- ☐ Motor vehicle accident
- ☐ Work / Job

Is there a worker's comp claim? ○Yes /○No
Do you have an attorney? ○Yes /○No

Date of Injury? _____

How long have you had Symptoms: _____

Diagnosis (if you know or have been told)?
_____

Previous Treatments (PT, Surgery, etc.)
_____
_____

Have you had injections into your hip or bursa?
_____

Sports Level: ○none ○recreational ○competitive

What is your height and weight: _____
What would you like to do if you were not in pain: _____

Previous Surgeries (include dates)? _____
_____
_____
_____

How severe is the pain? (0 = none, 10 = severe pain)
At rest?
At its worst?

Do you have pain at night? ○Yes ○No
Does it waken you from sleep? ○Yes ○No
Can you lie on your side at night? ○Yes ○No
Is the pain getting:
○ Better ○ Worse ○ Same

What makes your problem better? _____
_____
What makes your problem worse? _____
_____

Are you currently working?
☐ Normal Job ☐ Limited Duty
Please describe your current limitations _____
_____
_____

Have you had any Imaging Studies?

X-rays	○Yes ○No	Date: _____
MRI	○Yes ○No	Date: _____
Cat Scan	○Yes ○No	Date: _____

Allergic to Latex? ○Yes ○No
Allergies to Medications or Foods? _____
Please list the Medications you take:
_____
_____
_____
_____

Do you have a history of Blood Clots or PE? ○Yes ○No
Does your family have a history of Blood Clots? ○Yes ○No
Do you have a Rheumatologic Condition? ○Yes ○No
Do you have CRPS or RSD? ○Yes ○No
Do/Did you have any heart problems? ○Yes ○No
Do/Did you have ulcers or gastritis? ○Yes ○No
Do/Did you have Diabetes? ○Yes ○No
Do/Did you have liver problems? ○Yes ○No
Do/Did you have kidney disease? ○Yes ○No
Do/Did you have Cancer? ○Yes ○No
Do/Did you smoke or chew tobacco? ○Yes ○No
Do you have HIV or Hepatitis C? ○Yes ○No
Do you have a bleeding disorder? ○Yes ○No
Do you tolerate tapes or adhesive? ○Yes ○No
Do you tolerate Metals? ○Yes ○No

Do you have adequate support to have Surgery? ○Yes ○No

HIP ARTHROSCOPY:

Labral Reconstruction

DR. BRIAN J. WHITE

Hip Intake Form
Brian J. White M.D.
Orthopaedic Surgeon – Specialist in Disorders of the Hip

WESTERN ORTHOPAEDICS

Name:_____

MR#:_____

Date:_____

Do you have pain with any of the following?

1. Long Sitting? ○ Yes ○ No
2. Long Driving or Travel? ○ Yes ○ No
3. Cycling? ○ Yes ○ No
4. Putting on shoes and socks? ○ Yes ○ No
5. Walking? ○ Yes ○ No
6. Running? ○ Yes ○ No
7. Pivoting/Twisting? ○ Yes ○ No
8. Squatting? ○ Yes ○ No

Do you have any of the following mechanical symptoms? (Please list symptoms if Yes) Giving way - Giving out - Catching - Painful popping - Non-painful popping

Pelvic Floor Questions:

1. Do you have pain or discomfort with intercourse? ○ Yes ○ No
2. Do you have bladder problems such as incontinence or urinary urgency? ○ Yes ○ No
3. Do you have difficulty or pain with bowel movements? ○ Yes ○ No
4. In addition to your hip pain do you have a deep pain near the sit bone area? ○ Yes ○ No
5. Females: Have you had children? ○ Yes ○ No

Please list all the areas where you are having pain?

Groin - Bikini line - Side of hip - Buttock - Front of thigh Other:

_____

Have you had any injections?

1. Into the side of hip or bursa? ○ Yes ○ No
If yes, how long was it helpful?

_____

What percentage of your symptoms did it take away? _____%

2. Into the hip joint by x-ray? ○ Yes ○ No
If yes, how long was it helpful?

_____

3. What percentage of your symptoms did it take away? _____%

Medications

1. Have you taken any anti-inflammatories or Tylenol? ○ Yes ○ No
2. How long, specifically, have you been taking them (not just as needed)? _____
3. Did you develop any issues/side effects from taking it? ○ Yes ○ No
If yes, please explain:

_____

_____

4. Please indicate what dosage and frequency:

_____

_____

Physical Therapy?

1. Have you done Physical Therapy for this? ○ Yes ○ No
2. Where did you go?

_____

3. How long did you attend?

_____

4. Did it completely fix the problem? ○ Yes ○ No
5. Have you done massage or chiropractic work? ○ Yes ○ No

How are you presently feeling?

1. My pain consistently negatively impacts my mood and overall life satisfaction. ○ Yes ○ No
2. Losing my identity as an athlete (someone who is active) and not being able to exercise has been really challenging for me. ○ Yes ○ No
3. I am struggling with not knowing how to relieve my stress now that I cannot exercise like I used to. ○ Yes ○ No
4. I am unclear how to accept my new “disability status” even if it may be temporary. ○ Yes ○ No
5. I fear the uncertainty of what my future holds, wondering if this is my “new normal” and whether I will ever be without pain again. ○ Yes ○ No

Practitioner’s notes:

Practitioner’s initials and date:
_____/_____