

NEXT GENERATION RADIOLOGY

HIP EVALUATION

Name _____
Last First Middle Initial

Age _____ Date _____

1. What was your chief complaint when you visited your doctor? _____

2. What does your doctor think caused your problem? _____

3. If you have any pain, instability or weakness of this hip please describe in severity and location. _____

4. Do you take any pills or medication for your hip problem? _____
If yes, what kind? _____

5. Have you ever broken any bones in this hip? _____

6. Have you ever dislocated this hip? _____

7. Have you had previous surgery or arthroscopy on this hip? _____
If yes, when was it done and what type of surgery was performed? _____

8. Have you had a prior MRI or CT study of this hip? _____ If yes, then where and when was it done? _____

9. Do you have any other medical problems? _____

10. Do you take any medications for these problems? _____
If yes, what kind? _____

Female Patients: Is there any chance you may be Pregnant? _____

Patient Signature _____