

## HARRIS HIP SCORE

Patient's name (or ref) \_\_\_\_\_

Clinician's name (or ref) \_\_\_\_\_ Patient's d.o.b. \_\_\_\_\_

### PAIN - check one

- None, or ignores it (44)
- Slight, occasional, no compromise in activities (40)
- Mild, no effect on average activities, rarely moderate pain with unusual activity, may take aspirin (30)
- Moderate pain, tolerable but makes concessions to pain. Some limitations of ordinary activity or work. May require occasional pain medication stronger than aspirin (20)
- Marked pain, serious limitation of activities (10)
- Totally disabled, crippled, pain in bed, bedridden (0)

### LIMP - check one

- None (11)
- Slight (8)
- Moderate (5)
- Severe or unable to walk (0)

### SUPPORT - check one

- None (11)
- Cane for long walks (8)
- Cane most of the time (5)
- One crutch (3)
- Two canes (2)
- Two crutches, walker or unable to walk (0)

### DISTANCE WALKED - check one

- Unlimited (11)
- Six blocks (8)
- Two or three blocks (5)
- Indoors only (2)
- Bed and chair only (0)

### SITTING - check one

- Comfortably in ordinary chair for one hour (5)
- On a high chair for 30 minutes (3)
- Unable to sit comfortably in any chair (0)

### PUBLIC TRANSPORTATION - check one

- Able to use (1)
- Not able to use (0)

### STAIRS - check one

- Normally without using a rail (4)
- Normally using a railing (2)
- In any manner (1)
- Unable to use stairs (0)

### PUT ON SHOES AND SOCKS - check one

- With ease (4)
- With difficulty (2)
- Unable (0)

### Absence of Deformity - All yes = 4 / Less than 4 = 0

- |  |                           |                          |
|--|---------------------------|--------------------------|
| Less than 30° fixed flexion contracture            | <input type="radio"/> Yes | <input type="radio"/> No |
| Less than 10° fixed abduction                      | <input type="radio"/> Yes | <input type="radio"/> No |
| Less than 10° fixed internal rotation in extension | <input type="radio"/> Yes | <input type="radio"/> No |
| Limb length discrepancy less than 3.2 cm           | <input type="radio"/> Yes | <input type="radio"/> No |

### Range of Motion - \*indicates normal

- Flexion (\*140°) \_\_\_\_\_
- Abduction (\*40°) \_\_\_\_\_
- Adduction (\*40°) \_\_\_\_\_
- External Rotation (\*40°) \_\_\_\_\_
- Internal Rotation (\*40°) \_\_\_\_\_

### Range of Motion Scale

- |                 |                 |               |
|-----------------|-----------------|---------------|
| 211° – 300° (5) | 101° – 160° (3) | 31° – 60° (1) |
| 161° – 210° (4) | 61° – 110° (2)  | 0° – 30° (0)  |

**RANGE OF MOTION SCORE:**

**TOTAL HARRIS HIP SCORE:**

## HIP DISABILITY AND OSTEOARTHRITIS OUTCOME SCORE (HOOS)

Patient's name (or ref) \_\_\_\_\_

Clinician's name (or ref) \_\_\_\_\_ Patient's d.o.b. \_\_\_\_\_

**INSTRUCTIONS:** This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.

**Answer every question by ticking the appropriate box. If you are unsure about how to answer a question, please give the best answer you can.**

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**SYMPTOMS** – These questions should be answered thinking of your hip symptoms during the **last week**.

**S1. Do you feel grinding, hear clicking or any other type of noise from you hip?** \_\_\_\_\_

Never       Rarely       Sometimes       Often       Always

**S2. Difficulties spreading legs wide apart** \_\_\_\_\_

None       Mild       Moderate       Severe       Extreme

**S3. Difficulties to stride out when walking** \_\_\_\_\_

None       Mild       Moderate       Severe       Extreme

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**STIFFNESS** – The following questions concern the amount of joint stiffness you have experienced during the **last week** in your hip. Stiffness is a sensation of restriction or slowness in the ease with which you move your hip joint.

**S4. How severe is your hip joint stiffness after first wakening in the morning?** \_\_\_\_\_

None       Mild       Moderate       Severe       Extreme

**S5. How severe is your hip stiffness after sitting, lying or resting later in the day?** \_\_\_\_\_

None       Mild       Moderate       Severe       Extreme

**SUBTOTAL:**  \_\_\_\_\_

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**PAIN**

**P1. How often is your hip painful?** \_\_\_\_\_

Never       Monthly       Weekly       Daily       Always

What amount of hip pain have you experienced the **last week** during the following activities?

**P2. Straightening your hip fully** \_\_\_\_\_

None       Mild       Moderate       Severe       Extreme

**P3. Bending your hip fully** \_\_\_\_\_

None       Mild       Moderate       Severe       Extreme

**P4. Walking on flat surface** \_\_\_\_\_

None       Mild       Moderate       Severe       Extreme

**PAIN** – CONTINUED

**P5. Going up or down stairs**

- None       Mild       Moderate       Severe       Extreme

**P6. At night while in bed**

- None       Mild       Moderate       Severe       Extreme

**P7. Sitting or lying**

- None       Mild       Moderate       Severe       Extreme

**P8. Standing upright**

- None       Mild       Moderate       Severe       Extreme

**P9. Walking on a hard surface** (asphalt, concrete, etc)

- None       Mild       Moderate       Severe       Extreme

**P10. Walking on an uneven surface**

- None       Mild       Moderate       Severe       Extreme

**SUBTOTAL:**

**FUNCTION, DAILY LIVING**

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself.

For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

**A1. Descending stairs**

- Never       Monthly       Weekly       Daily       Always

**A2. Ascending stairs**

- None       Mild       Moderate       Severe       Extreme

**A3. Rising from sitting**

- None       Mild       Moderate       Severe       Extreme

**A4. Standing**

- None       Mild       Moderate       Severe       Extreme

**A5. Bending to floor/pick up an object**

- None       Mild       Moderate       Severe       Extreme

**A6. Walking on flat surface**

- None       Mild       Moderate       Severe       Extreme

**A7. Getting in/out of car**

- None       Mild       Moderate       Severe       Extreme

**A8. Going shopping**

- None       Mild       Moderate       Severe       Extreme

**A9. Putting on socks/stockings**

- None       Mild       Moderate       Severe       Extreme

**A10. Rising from bed**

- None       Mild       Moderate       Severe       Extreme

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**FUNCTION, DAILY LIVING – CONTINUED**

**A11. Taking off socks/stockings** \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

**A12. Lying in bed** (turning over, maintaining hip position) \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

**A13. Getting in/out of bath** \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

**A14. Sitting** \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

**A15. Getting on/off toilet** \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

**A16. Heavy domestic duties** (moving heavy boxes, scrubbing floors, etc) \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

**A17. Light domestic duties** (cooking, dusting, etc) \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

**SUBTOTAL:**

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**FUNCTION, SPORTS AND RECREATIONAL ACTIVITIES** – The following questions concern your physical function when being active on a higher level. The questions should be answered thinking of what degree of difficulty you have experienced during the **last week** due to your hip.

**SP1. Squatting** \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

**SP2. Running** \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

**SP3. Twisting/pivoting on your injured knee** \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

**SP4. Walking on uneven surface** \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

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**QUALITY OF LIFE:**

**Q1. How often are you aware of your hip problem?** \_\_\_\_\_

- Never       Monthly       Weekly       Daily       Constantly

**Q2. Have you modified your life style to avoid potentially damaging activities to your hip?** \_\_\_\_\_

- Not at all       Mildly       Moderately       Severely       Totally

**Q3. How much are you troubled with lack of confidence in your hip?** \_\_\_\_\_

- Not at all       Mildly       Moderately       Severely       Extremely

**Q4. In general, how much difficulty do you have with your hip?** \_\_\_\_\_

- None       Mild       Moderate       Severe       Extreme

**SUBTOTAL:**

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**THE HOOS HIP SURVEY SCORE IS**