UKFASHION
STUDYING HIP IMPINGEMENT

SITE ID
PATIENT ID FAS-
DATE

MONTHS 6 12

# Patient Questionnaire

**INSTRUCTIONS**

Please read all the instructions before completing the questionnaire

Please follow the instructions for each section carefully.

Please answer all the questions. Although it may seem that questions are asked more than once, it is still important that you answer every one.

## We would like to know about your ☐ left ☐ right hip

Date of completion / /

## PART 1 | INSTRUCTIONS

- These questions ask about the problems you may be experiencing in your hip, how these problems affect your life, and the emotions you may feel because of these problems.
- Please answer each question with respect to the current status, function, circumstances and beliefs related to your hip.
- Consider the last month.
- The questions are formatted so that you can indicate the severity of the problem by marking the line below the question.

**PLEASE NOTE**

Please mark the line with a slash at the point which most closely represents your situation.

- If you put a mark on the far left, it means that you feel you are significantly impaired. For example:

significantly impaired / _____ no problems at all

- If you put a mark on the far right, it means that you do not think that you have any problems with your hip. For example:

significantly impaired _____ / no problems at all

- If the mark is placed in the middle of the line, this indicates that you are moderately disabled, or in other words, between the extremes of 'significantly impaired' and 'no problems at all'. It is important to put your mark at either end of the line if the extreme descriptions accurately reflect your situation.

If the question asks about something that you do not experience, please tick the option:

☑ I do not do this action in my activities

where this is appropriate.

## PART 1 | SECTION 1 | SYMPTOMS AND FUNCTIONAL LIMITATIONS

The following questions ask about symptoms that you may experience in your hip and about the function of your hip with respect to daily activities. Please think about how you have felt most of the time over the past month and answer accordingly.

**Q01** How often does your hip/groin ache?

constantly _____ never

**Q02** How stiff is your hip as a result of sitting/resting during the day?

extremely stiff _____ not stiff at all

**Q03** How difficult is it for you to walk long distances?

extremely difficult _____ not difficult at all

**Q04** How much pain do you have in your hip while sitting?

extreme pain _____ no pain at all

**Q05** How much trouble do you have standing on your feet for long periods of time?

severe trouble _____ no trouble at all

**Q06** How difficult is it for you to get up and down off the floor/ground?

extremely difficult _____ not difficult at all

**Q07** How difficult is it for you to walk on uneven surfaces?

extremely difficult _____ not difficult at all

**Q08** How difficult is it for you to lie on your affected hip side?

extremely difficult _____ not difficult at all

**Q09** How much trouble do you have with stepping over obstacles?

severe trouble _____ no trouble at all

**Q10** How much trouble do you have with climbing up/down stairs?

severe trouble _____ no trouble at all

**Q11** How much trouble do you have with rising from a sitting position?

severe trouble _____ no trouble at all

**Q12** How much discomfort do you have with taking long strides?

extreme discomfort _____ no discomfort at all

**Q13** How much difficulty do you have with getting into and/or out of a car?

extreme difficulty _____ no difficulty at all

**Q14** How much trouble do you have with grinding, catching or clicking in your hip?

severe trouble _____ no trouble at all

**Q15** How much difficulty do you have with putting on/taking off socks, stockings or shoes?

extreme difficulty _____ no difficulty at all

**Q16** Overall, how much pain do you have in your hip/groin?

extreme pain _____ no pain at all

## PART 1 | SECTION 2 | SPORTS AND RECREATIONAL ACTIVITIES

The following questions ask about your **hip** when you participate in sports and recreational activities. Please think about how you have felt most of the time over the past **month** and answer accordingly.

**Q17** How concerned are you about your ability to maintain your desired fitness level?

extremely concerned _____ not concerned at all

**Q18** How much pain do you experience in your hip after activity?

extreme pain _____ no pain at all

**Q19** How concerned are you that the pain in your hip will increase if you participate in sports or recreational activities?

extremely concerned _____ not concerned at all

**Q20** How much has your quality of life deteriorated because you cannot participate in sport/recreational activities?

extremely deteriorated _____ not deteriorated at all

**Q21** How concerned are you about cutting/changing directions during your sport or recreational activities?

☐ I do not do this action in my activities

extremely concerned _____ not concerned at all

**Q22** How much has your performance level decreased in your sport or recreational activities?

extremely decreased _____ not decreased at all

## PART 1 | SECTION 3 | JOB RELATED CONCERNS

The following questions relate to your hip with respect to your current work. Please think about how you have felt most of the time over the past month and answer accordingly.

☐ I do not work because of my hip *(please skip section)*
☐ I do not work for reasons other than my hip *(please skip section)*

**Q23** How much trouble do you have pushing, pulling, lifting or carrying heavy objects at work?

☐ I do not do these actions in my activities

severe trouble _____ no trouble at all

**Q24** How much trouble do you have with crouching/squatting?

severe trouble _____ no trouble at all

**Q25** How concerned are you that your job will make your hip worse?

extremely concerned _____ not concerned at all

**Q26** How much difficulty do you have at work because of reduced hip mobility?

extreme difficulty _____ no difficulty at all

**PART 1** | SECTION 4 | SOCIAL, EMOTIONAL AND LIFESTYLE CONCERNS

The following questions ask about social, emotional and lifestyle concerns that you may feel with respect to your hip problem. Please think about how you have felt most of the time over the past month and answer accordingly.

**Q27** How frustrated are you because of your hip problem?

extremely frustrated _____ not frustrated at all

**Q28** How much trouble do you have with sexual activity because of your hip?

☐ This is not relevant to me

severe trouble _____ no trouble at all

**Q29** How much of a distraction is your hip problem?

extreme distraction _____ no distraction at all

**Q30** How difficult is it for you to release tension and stress because of your hip problem?

extremely difficult _____ not difficult at all

**Q31** How discouraged are you because of your hip problem?

extremely discouraged _____ not discouraged at all

**Q32** How concerned are you about picking up or carrying children because of your hip?

☐ I do not do this action in my activities

extremely concerned _____ not concerned at all

**Q33** How much of the time are you aware of the disability in your hip?

constantly aware _____ not aware at all

## PART 2

This information will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by placing a check mark on the line in front of the appropriate answer. It is not specific for arthritis. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

**Q01** In general, would you say your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

The following two questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

**Q02** Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:

☐ Yes, Limited A Lot
☐ Yes, Limited A Little
☐ No, Not Limited At All

**Q03** Climbing several flights of stairs:

☐ Yes, Limited A Lot
☐ Yes, Limited A Little
☐ No, Not Limited At All

During the past 4 weeks have you had any of the following problems with your work or other regular activities as a result of your physical health?

**Q04** Accomplished less than you would like:

☐ Yes ☐ No

**Q05** Were limited in the kind of work or other activities:

☐ Yes ☐ No

During the past 4 weeks, were you limited in the kind of work you do or other regular activities as a result of any emotional problems (such as feeling depressed or anxious)?

**Q06** Accomplished less than you would like:

☐ Yes ☐ No

**Q07** Didn't do work or other activities as carefully as usual:

☐ Yes ☐ No

**Q08** During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- ☐ Not At All
- ☐ A Little Bit
- ☐ Moderately
- ☐ Quite A Bit
- ☐ Extremely

The next three questions are about how you feel and how things have been during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

**Q09** Have you felt calm and peaceful?

- ☐ All of the Time
- ☐ Most of the Time
- ☐ A Good Bit of the Time
- ☐ Some of the Time
- ☐ A Little of the Time
- ☐ None of the Time

**Q10** Did you have a lot of energy?

- ☐ All of the Time
- ☐ Most of the Time
- ☐ A Good Bit of the Time
- ☐ Some of the Time
- ☐ A Little of the Time
- ☐ None of the Time

**Q11** Have you felt downhearted and blue?

- ☐ All of the Time
- ☐ Most of the Time
- ☐ A Good Bit of the Time
- ☐ Some of the Time
- ☐ A Little of the Time
- ☐ None of the Time

**Q12** During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- ☐ All of the Time
- ☐ Most of the Time
- ☐ A Good Bit of the Time
- ☐ Some of the Time
- ☐ A Little of the Time
- ☐ None of the Time

**PART 3**

The following questions ask you about your general health state at the moment. By ticking one box in each group below, please indicate which statement best describes your own health state today.

**Q01** Mobility

- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walk about

**Q02** Self-care

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

**Q03** Usual activities (eg work, study, housework, family or leisure activities)

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

**Q04** Pain or discomfort

- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

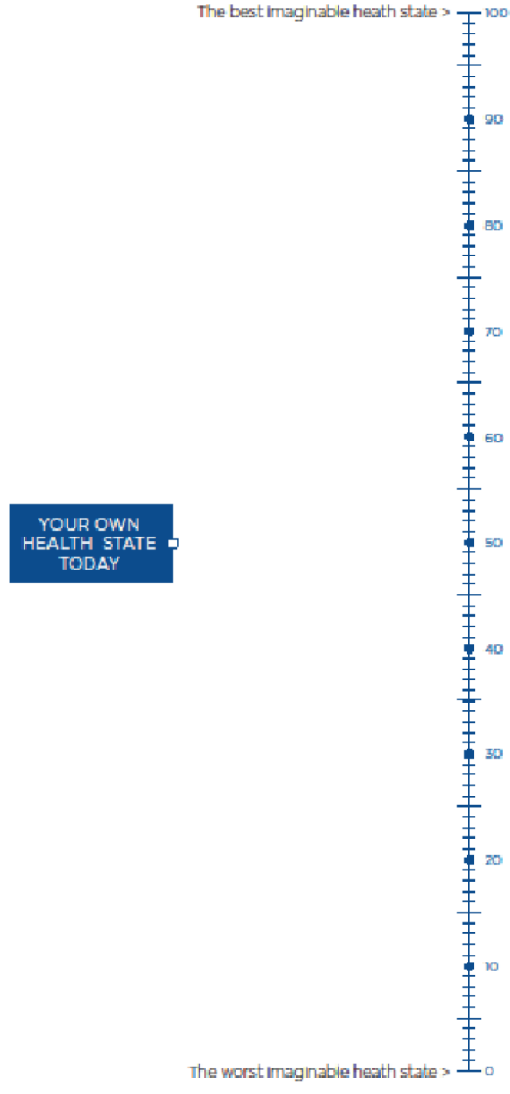
**Q05** Anxiety or depression

- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed

**Q06** Health State

To help people say how good or bad a health status is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked by 100 and the worst state you can imagine is marked by 0.

Please mark an 'X' on the scale below to indicate how your health is **today** and then write the number you marked on the scale in the box at bottom right.



## PART 6

**Q01** In the past 3 months have you been treated for any of the following events?

| | | | |
|---|---|---|---|
| Wound complication (If you have had surgery) | ☐ Yes | ☐ No | ☐ N/A |
| Unplanned surgery because of your femoroacetabular impingement | ☐ Yes | ☐ No | |
| A regional pain syndrome | ☐ Yes | ☐ No | |
| Deep Vein Thrombosis (DVT) | ☐ Yes | ☐ No | |
| If yes, did you see the DVT nurse | ☐ Yes | ☐ No | |
| If yes, were you prescribed medication? | ☐ Yes | ☐ No | |

**Q02** Any other complications? ☐ Yes ☐ No

If yes, please specify:

**Q03** Have you had any other unscheduled appointment at hospital because of you femoroacetabular impingement. ☐ Yes ☐ No

If you are unsure about any of these questions please cross here ☐ and someone from the research team will get in contact with you to help you answer these questions.

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That is the end of the questionnaire.

Please check that you have completed all sections.

Please keep a record of any days off work and hospital or medical procedures you under go as a result of your hip impingement.

In three months we will send you another questionnaire which will ask you for these details. Please use the reply-paid envelope to return that questionnaire to us.

**Thank you very much for your time.**

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# Health Economics: **6 Month Follow-up**

We would like to find out about your contacts with health and social services over the last 6 months and any extra costs that have been incurred over the same period as a result of your health. Your answers are strictly confidential and anonymous. Your answers are important because they will give persons who make decisions about patient treatment within the National Health Service an idea of the costs involved.

## INPATIENT / DAY CARE

**Q01** Over the last 6 months have you been admitted to hospital as an inpatient or for day case care? ☐ Yes ☐ No

If yes, please tell us if you can which department of the hospital you went to (speciality) and the number of days you were in hospital. If the speciality is not listed, then please write in the speciality or part of your body as best you can in the box provided.

| SPECIALTY | NAME OF HOSPITAL AND WARD | NO OF DAYS IN HOSPITAL |
|---|---|---|
| Orthopaedics (your hip/leg) | | |
| Orthopaedics (any other bones) | | |
| Rehabilitation unit | | |
| For any day case care | | |
| For any other surgery<br>Please specify here<br>..... | | |
| Please specify here<br>..... | | |
| Please specify here<br>..... | | |

## OUTPATIENT CARE

**Q02** Over the last 6 months have you visited an outpatient clinic in hospital?

☐ Yes ☐ No

If yes, please write the number of visits in the last 6 months in the appropriate box below. If the type of outpatient clinic you attended is not listed then please write this in at the end of the table.

| OUTPATIENT CLINIC | NO OF VISITS OVER THE PAST 6 MONTHS |
|---|---|
| Orthopaedics (about your hip/leg) | |
| Physiotherapy outpatient clinic (about your hip/leg) | |
| Physiotherapy outpatient clinic (any other reason) | |
| Accident & Emergency | |
| For any other visits<br>Please specify here | |
| Please specify here | |

## COMMUNITY CARE

**Q03** In the past 6 months, have you seen any health care professionals in the community? ☐ Yes ☐ No

If yes, please indicate the number of contacts over the past 6 months and the average duration of these contacts in minutes. If the type of support you have received is not listed then please write this in at the end of the table.

| SERVICE | NO OF CONTACTS OVER PAST 6 MONTHS | AVERAGE DURATION OF CONTACT (MINUTES) |
|---|---|---|
| GP visits in surgery | | |
| GP home visits | | |
| GP telephone contacts | | |
| Practice nurse contacts | | |
| District nurse contacts | | |
| Community physiotherapy contacts | | |
| For any other contact<br>Please specify here | | |
| Please specify here | | |
| Please specify here | | |

**Q04** Over the past 6 months, have you been provided with personal social services to make your day to day life easier to manage? ☐ Yes ☐ No

If yes, in the following table please indicate the number of contacts with the service over the last 6 months and the average duration of these contacts in minutes. If the type of support you have received is not listed then please write this in at the end of the table.

| SERVICE | NO OF TIMES OVER PAST 6 MONTHS | AVERAGE DURATION OF CONTACT (MINUTES) |
|---|---|---|
| Meals on wheels (frozen, daily) | | |
| Meals on wheels (hot, daily) | | |
| Laundry services | | |
| Social worker contacts | | |
| Care worker contacts including help at home | | |
| Community physiotherapy contacts | | |
| For any other service<br>Please specify here ..... | | |
| Please specify here ..... | | |
| Please specify here ..... | | |

## MEDICATIONS

**Q05** Have you been prescribed or bought any new medications over the past 6 months? ☐ Yes ☐ No

If yes, please note any medications (including pain relief) that you have been prescribed by a doctor or other health care professional in the past 6 months. Also please include any medication that you have bought yourself without a prescription ("over the counter").

| MEDICATION & DOSAGE | NO TIMES DAILY | NO OF DAYS USED | TYPE |
|---|---|---|---|
| EXAMPLE *Ibuprofen topical gel 25ml* | *x3* | *14* | ☐ Prescription ☒ Over the counter |
| | | | ☐ Prescription ☐ Over the counter |
| | | | ☐ Prescription ☐ Over the counter |
| | | | ☐ Prescription ☐ Over the counter |
| | | | ☐ Prescription ☐ Over the counter |
| | | | ☐ Prescription ☐ Over the counter |
| | | | ☐ Prescription ☐ Over the counter |
| | | | ☐ Prescription ☐ Over the counter |
| | | | ☐ Prescription ☐ Over the counter |
| | | | ☐ Prescription ☐ Over the counter |

## AIDS AND ADAPTATIONS

**Q06** Have you received or bought any aid or adaptations as a result of your health over the past 6 months? ☐ Yes ☐ No

If yes, in the following table, please indicate the number of aids or items of equipment received. If an item you have received is not listed please write this in and the quantity.

| AID OR ADAPTATION | NO RECEIVED | COST (£) (if bought yourself) |
|---|---|---|
| Crutches | | |
| Stick | | |
| Walking frame | | |
| Grab rail | | |
| Dressing aids | | |
| Long-handle shoe horns | | |
| Other<br>Please specify here<br>..... | | |
| Please specify here<br>..... | | |
| Please specify here<br>..... | | |

## ADDITIONAL INFORMATION

**Q07** Please think of any additional costs over the past 6 months to you, your partner, other family members and friends that have been incurred as a result of your contact with health or social care services or your general health state. If a category of cost is not listed below please add it at the bottom of the table.

| NATURE OF COST | COST TO YOU | COST TO PARTNER | COST TO RELATIVES/ FRIENDS |
|---|---|---|---|
| Lost earnings<br>Do not record if annual or compassionate leave was taken or the time off work was made up at a later point | | | |
| Childcare | | | |
| Help with housework | | | |
| Special equipment | | | |
| Other<br>Please specify here ..... | | | |
| Please specify here ..... | | | |
| Please specify here ..... | | | |
| Please specify here ..... | | | |
| Please specify here ..... | | | |
| Please specify here ..... | | | |
| Please specify here ..... | | | |

**Q08** Are you currently working (please tick)?

☐ Yes If yes, what is your main job? (please specify below)

.....

☐ No If no, is this because of (please tick):

- ☐ Your hip condition
- ☐ Other health reason
- ☐ Unable to work for other reason
- ☐ Retired

**Q09** Please indicate if, over the last 6 months, you have received any of the benefits below. If a benefit you are receiving is not listed below please add it at the bottom of the table.

| BENEFIT | BENEFIT RECEIVED OVER THE PAST 6 MONTHS | IF YES, PLEASE ESTIMATE AMOUNT RECEIVED PER WEEK (£) |
|---|---|---|
| Attendance Allowance | ☐ Yes ☐ No | |
| Income Support | ☐ Yes ☐ No | |
| Jobseeker's Allowance | ☐ Yes ☐ No | |
| Housing Benefit | ☐ Yes ☐ No | |
| Child tax credit | ☐ Yes ☐ No | |
| Disability Living Allowance – mobility | ☐ Yes ☐ No | |
| Disability Living Allowance – caring | ☐ Yes ☐ No | |
| Pension Credit | ☐ Yes ☐ No | |
| Council Tax Benefit | ☐ Yes ☐ No | |
| Carer's Allowance | ☐ Yes ☐ No | |
| Statutory Sick Pay | ☐ Yes ☐ No | |
| Employment and Support Allowance | ☐ Yes ☐ No | |
| Other<br>Please specify here<br>..... | | |
| Please specify here<br>..... | | |