



HIP DISABILITY AND OSTEOARTHRITIS OUTCOME SCORE (HOOS)

Patient Name: _____ **Date:** _____

INSTRUCTIONS: This survey asks for your view about your hip. This information will help us keep track of how you feel about your knee 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

Symptoms – These questions should be answered thinking of your hip symptoms during the last week				
S1. Do you feel grinding, hearing clicking, or any other type of noise from your hip?				
<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
S2. Difficulties spreading legs wide apart				
<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always
S3. Difficulties to stride out when walking				
<input type="checkbox"/> Never	<input type="checkbox"/> Rarely	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Often	<input type="checkbox"/> Always

Stiffness – The following questions concern the amount of joint stiffness you have experienced during the last week in your knee. Stiffness is a sensation of restriction or slowness in the ease with which you move your knee joint.				
S4. How severe is your hip joint stiffness after first wakening in the morning?				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
S5. How severe is your hip stiffness after sitting, lying, or resting later in the day?				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

Pain				
P1. How often is your hip painful				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
P2. Straightening your hip fully				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
P3. Bending your hip fully				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
P4. Walking on flat surface				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
P5. Going up or down stairs				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
P6. At night while in bed				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
P7. Sitting or lying				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
P8. Standing upright				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always



P9. Waling on a hard surface (asphalt, concrete, ect.)				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always
P10. Walking on an uneven surface				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Always

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				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A2. Ascending stairs				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A3. Rising from sitting				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A4. Standing				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A5. Bending to floor/pick up an object				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A6. Walking on flat surface				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A7. Getting in/out of car				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A8. Going shopping				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A9. Putting on socks/stockings				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A10. Rising from bed				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A11. Taking off socks/stockings				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A12. Lying in bed (turning over, maintaining knee position)				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A13. Getting in/out of bath				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A14. Sitting				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A15. Getting on/off toilet				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
A16. Heavy domestic duties (moving heavy boxes, scrubbing floors, ect.)				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme



A17. Light domestic duties (cooking, dusting, ect.)				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

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				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
SP2. Running				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
SP3. Jumping				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
SP4. Twisting/pivoting on your injured hip				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme
SP5. Walking on uneven surface				
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Extreme

Quality of Life				
Q1. How often are you aware of your hip problem?				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Constantly
Q2. Have you modified your lifestyle to avoid potentially damaging activities to your hip?				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Constantly
Q3. How much are you troubled with lack of confidence in your hip?				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Constantly
Q4. In general, how much difficulty do you have with your hip?				
<input type="checkbox"/> Never	<input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily	<input type="checkbox"/> Constantly