WOMAC Survey Form

Name: _____ Date: _____

Instructions: In sections A, B, and C, questions will be asked about your hip or knee pain. Please mark each response with an X. If you are unsure about how to answer a question, please give the best answer you can.

A. How much pain do you have (during the last 48 hours)?

| | None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|---|
| 1. Walking on a flat surface | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Going up and down stairs | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. At night while in bed, pain disturbs your sleep | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Sitting or lying | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Standing upright | ☐ | ☐ | ☐ | ☐ | ☐ |

B. Think about the stiffness (not pain) you have in your hip/knee during the last 48 hours.

| | None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|---|
| 6. How severe is your stiffness after first awakening in the morning? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. How severe is your stiffness after sitting, lying, or resting in the day? | ☐ | ☐ | ☐ | ☐ | ☐ |

C. Think about the difficulty you had in doing the following daily physical activities due to your hip/knee during the last 48 hours.

| | None | Mild | Moderate | Severe | Extreme |
|---|---|---|---|---|---|
| 8. Descending stairs | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Ascending stairs | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Rising from sitting | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Standing | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Bending to the floor | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Walking on flat surfaces | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. Getting in and out of a car, or on or off a bus | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. Going shopping | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. Putting your socks or stockings | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. Rising from the bed | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18. Taking off your socks or stockings | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19. Lying in bed | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20. Getting in or out of the bath | ☐ | ☐ | ☐ | ☐ | ☐ |
| 21. Sitting | ☐ | ☐ | ☐ | ☐ | ☐ |
| 22. Getting on or off the toilet | ☐ | ☐ | ☐ | ☐ | ☐ |
| 23. Performance heavy domestic duties | ☐ | ☐ | ☐ | ☐ | ☐ |
| 24. Performing light domestic duties | ☐ | ☐ | ☐ | ☐ | ☐ |

# PATIENT ASSESSMENT QUESTIONAIRE **HIP**

Name: _____ Date: _____

**1. Have you had pain recently (within the last 3 months) on the affected hip? (Please circle responses)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Right Side:** | **Yes / No** | | | | | | |
| **If yes,** | **location:** | Buttock | Groin | Thigh | Side | Lower Back | Knee |
| | **Severity:** | None | Mild | Moderate | Severe | Excruciating | |
| | **Frequency:** | Never | Rarely | Occasionally | Frequently | Always | |
| **Left Side:** | **Yes / No** | | | | | | |
| **If yes,** | **location:** | Buttock | Groin | Thigh | Side | Lower Back | Knee |
| | **Severity:** | None | Mild | Moderate | Severe | Excruciating | |
| | **Frequency:** | Never | Rarely | Occasionally | Frequently | Always | |

**2. Do you limp?** Never Rarely Occasionally Frequently Always
**If yes, because of your:** right hip / left hip / both hips

**3. Do you have difficulty with:**

| | | | | | |
|---|---|---|---|---|---|
| **a. putting on socks/shoes?** | None | Slight | Moderate | Great | Unable |
| **b. personal care (toilet, bathing, etc)** | None | Slight | Moderate | Great | Unable |
| **c. household activities (cleaning, etc)** | None | Slight | Moderate | Great | Unable |
| **d. getting in and out of a car?** | None | Slight | Moderate | Great | Unable |

**4. How much assistance do you need with going up and down stairs?**

None cane/crutch/banister 2 crutches walker/someone's assistance Unable

**5. How far can you walk? (before your pain limits you)**

Unlimited 10+ blocks 4-10 blocks 1-3 blocks Housebound

**6. Please select your favorite recreational activities and how often you would participate in them:**

| | | | | | |
|---|---|---|---|---|---|
| **a. Walking (>1 mile)** | Never | Rarely | Occasionally | Frequently | Always |
| **b. Running** | Never | Rarely | Occasionally | Frequently | Always |
| **c. Swimming** | Never | Rarely | Occasionally | Frequently | Always |
| **d. Gym Workout** | Never | Rarely | Occasionally | Frequently | Always |
| **e. Tennis** | Never | Rarely | Occasionally | Frequently | Always |
| **f. Golf** | Never | Rarely | Occasionally | Frequently | Always |
| **g. Gardening** | Never | Rarely | Occasionally | Frequently | Always |
| **h. Other:_____** | Never | Rarely | Occasionally | Frequently | Always |

**How often does your affected hip influence or prohibit the performance of these activities?**

Never Rarely Occasionally Frequently Always

**7. How often does your affected hip influence your social activities? (recreation, traveling)**

Never Rarely Occasionally Frequently Always

**8. How often does your hip pain influence your sense of well being? (emotionally, mentally)**

Never Rarely Occasionally Frequently Always

**9. Please rate your degree of satisfaction with your ability to use your hip.**

Unsatisfied 0 1 2 3 4 5 6 7 8 9 10 Fully Satisfied