

VALIDATED QUESTIONNAIRE

OXFORD HIP QUESTIONNAIRE

When answering the questions please only consider how you have been getting on during the past four weeks

- | | | | |
|---|--------------|--|--------------|
| 1 How would you describe the pain you have usually from your left/right hip? | Score | 5 Have you been able to do your household shopping on your own? | Score |
| <input type="checkbox"/> None | 1 | <input type="checkbox"/> Yes, easily | 1 |
| <input type="checkbox"/> Very mild | 2 | <input type="checkbox"/> With little difficulty | 2 |
| <input type="checkbox"/> Mild | 3 | <input type="checkbox"/> With moderate difficulty | 3 |
| <input type="checkbox"/> Mild Moderate | 4 | <input type="checkbox"/> With extreme difficulty | 4 |
| <input type="checkbox"/> Severe | 5 | <input type="checkbox"/> No, impossible | 5 |
| 2 Have you had any trouble with washing and drying yourself (all over) because of your left/right hip? | | 6 For how long have you been able to walk before the pain from your left/right hip became severe? (with or without a stick) | |
| <input type="checkbox"/> No trouble at all | 1 | <input type="checkbox"/> No pain, even after more than 30 minutes | 1 |
| <input type="checkbox"/> Very little trouble | 2 | <input type="checkbox"/> 16 to 30 minutes | 2 |
| <input type="checkbox"/> Moderate trouble | 3 | <input type="checkbox"/> 5 to 15 minutes | 3 |
| <input type="checkbox"/> Extreme difficulty | 4 | <input type="checkbox"/> Around the house only | 4 |
| <input type="checkbox"/> Impossible to do | 5 | <input type="checkbox"/> Unable to walk at all | 5 |
| 3 Have you had any trouble getting in and out of a car or using public transport because of your left/right hip? (whichever you tend to use) | | 7 Have you been able to climb a flight of stairs? | |
| <input type="checkbox"/> No trouble at all | 1 | <input type="checkbox"/> Yes, easily | 1 |
| <input type="checkbox"/> Very little trouble | 2 | <input type="checkbox"/> With little difficulty | 2 |
| <input type="checkbox"/> Moderate trouble | 3 | <input type="checkbox"/> With moderate difficulty | 3 |
| <input type="checkbox"/> Extreme difficulty | 4 | <input type="checkbox"/> With extreme difficulty | 4 |
| <input type="checkbox"/> Impossible to do | 5 | <input type="checkbox"/> No, impossible | 5 |
| 4 Have you been able to put on a pair of socks, stockings or tights? | | 8 After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your left/right hip? | |
| <input type="checkbox"/> Yes, easily | 1 | <input type="checkbox"/> Not at all painful | 1 |
| <input type="checkbox"/> With little difficulty | 2 | <input type="checkbox"/> Slightly painful | 2 |
| <input type="checkbox"/> With moderate difficulty | 3 | <input type="checkbox"/> Moderately painful | 3 |
| <input type="checkbox"/> With extreme difficulty | 4 | <input type="checkbox"/> Very painful | 4 |
| <input type="checkbox"/> No, impossible | 5 | <input type="checkbox"/> Unbearable | 5 |

VALIDATED QUESTIONNAIRE

	Score		Score
<p>9 Have you been limping when walking, because of your left/right hip?</p> <p><input type="checkbox"/> Rarely / never</p> <p><input type="checkbox"/> Sometimes or just at first</p> <p><input type="checkbox"/> Often, not just at first</p> <p><input type="checkbox"/> Most of the time</p> <p><input type="checkbox"/> All of the time</p>	<p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p>	<p>1 How much pain from your left/right hip interfered with your usual work (including housework)?</p> <p><input type="checkbox"/> Not at all</p> <p><input type="checkbox"/> A little bit</p> <p><input type="checkbox"/> Moderately</p> <p><input type="checkbox"/> Greatly</p> <p><input type="checkbox"/> Totally</p>	<p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p>
<p>1 Have you had any sudden, severe pain – ‘shooting’, ‘stabbing’ or ‘spasms’ – from your left / right hip?</p> <p><input type="checkbox"/> No days</p> <p><input type="checkbox"/> Only 1 or 2 days</p> <p><input type="checkbox"/> Some days</p> <p><input type="checkbox"/> Most days</p> <p><input type="checkbox"/> Every day</p>	<p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p>	<p>1 Have you been troubled by pain from your left / right hip in bed at night?</p> <p><input type="checkbox"/> No nights</p> <p><input type="checkbox"/> Only 1 or 2 nights</p> <p><input type="checkbox"/> Some nights</p> <p><input type="checkbox"/> Most nights</p> <p><input type="checkbox"/> Every nights</p>	<p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p>