http://dx.doi.org/10.2106/JBJS.15.00798

Appendix 1

Date of completion ___ / ___ / _____ **Case Identifier_____**

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ANCHOR

Young Adult Hip Patient Information

Today's Date M M D D Y Y Y Y

☐ Initial Visit ☐ 1 YR ☐ 2 YR ☐ 5 YR ☐ 10 YR ☐ Other_____

First Name | Middle Initial | Last Name

Home/Cell Number ___-___ Alternative Number ___-___

E-Mail Address

Which hip is being (or was) operated on?

☐1 Right ☐2 Left

Sex:

☐1 Male ☐2 Female

Marital Status:

☐1Single ☐2Separated ☐3Widowed

☐4Divorced ☐5Married

Has anyone in your family had hip surgery?

☐1 **Yes** (If *yes*, please check all that apply)

___1Parent
___2Child
___3Brother/Sister
___4Aunt/Uncle
___5Cousin

☐2 **No**

Ethnicity/ Race (Please check all that apply):

___1American Indian
___2Asian American
___3Black/ African American
___4Hispanic
___5Native Hawaiian
___6White/ Caucasian
___7Other: _____

	M M	D D	Y E A R
Date of Birth			
Date of Surgery			

Procedure (Staff to Complete all that apply):

☐ PAO ☐ Arthroscopy ☐ THA

☐ SD ☐ Limited Open Osteochondroplasty

☐ PFO ☐ Resurfacing ☐ Revision THA

Surgeon _____

What is your current occupation?
(If you are not working now, what was your past occupation?)

At this time, are you?

___1Working full time
___2Working part time
___3Homemaker
___4Retired
___5Student
___6Disabled
___7Other (describe): _____

How many years of school have you completed?
(e.g. 1 = 1st grade, 12 = high school senior, 13 = college freshman, etc.)

___1	___6	___11	___16
___2	___7	___12	___17
___3	___8	___13	___18
___4	___9	___14	___19
___5	___10	___15	___20

Estimate the number of hours you work per week: ☐☐

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How many other people live at home with you? ☐☐

(Check all that apply)
___I live alone
___Parents
___Spouse/ partner
___Sons or daughters
___Brothers or sisters
___Other (describe): _____

Your height: ☐ **ft.** ☐☐ **in.**

Your weight: ☐☐☐ **lbs.**

Treatment:

Have you had additional surgery on your hip? ☐ 1 Yes ☐ 2 No

If YES, what type of surgery? _____

What was the date of your additional surgery? M M ☐☐ D D ☐☐ Y Y Y Y ☐☐☐☐

Have you had surgery on your other hip? ☐ 1 Yes ☐ 2 No

If YES, what type of surgery? _____

What was the date of your additional surgery? M M ☐☐ D D ☐☐ Y Y Y Y ☐☐☐☐

Have you sought treatment for back pain, knee pain or hip pain other than in your surgical hip since your last visit? ☐ 1 Yes ☐ 2 No

If YES, what type of treatment was given:
___1 Injection
___2 Medication
___3 Physical Therapy
___4 Surgery

Have you had any major surgeries or hospitalizations (other than what was indicated above) since your last visit? ☐ 1 Yes ☐ 2 No

If YES: What type of surgery? _____
Hospitalization reason? _____

What was the date of your surgery or hospitalization? M M ☐☐ D D ☐☐ Y Y Y Y ☐☐☐☐

Other Illnesses:

Do you have any other illnesses that currently limit your activity? (ex. Heart disease, lung disease, neurological disease) ☐ 1 Yes ☐ 2 No

If YES, please list the illness(-es) _____
_____
_____
_____

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Patient History

1. **COMMOM HEALTH PROBLEMS:**

The following is a list of common health problems. Please indicate yes in the first column if you **do** have the problem. If you **do not** have the problem, go to the next health problem. If you do have the problem, please indicate in the second column if you receive medications or some other form of treatment for the problem. In the third column, please indicate if the problem limits any of your activities. In the last column, please indicate the year or your age when the problem began.

	Do you have the problem?		**Do you receive treatment for it?**		**Does it limit your activities?**		**When did this problem begin?**		
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Year**	or	**Age**
Heart disease	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
High blood pressure	☐1	☐2	☐1	☐2	☐	☐	☐☐☐☐		☐☐
Asthma or pulmonary (lung) Disease	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Diabetes	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Ulcer or stomach Disease	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Bowel disease	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Kidney disease	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Liver disease	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Anemia or other Blood disease	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Overweight	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Cancer	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Depression	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Osteoarthritis, degenerative arthritis	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Rheumatoid arthritis	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Back pain	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Lyme disease	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Alcoholism	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐
Other Medical Problem	☐1	☐2	☐1	☐2	☐1	☐2	☐☐☐☐		☐☐

Please specify "Other Medical Problem": _____

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Patient Functioning

UCLA Activity Score

Please indicate **(circle)** the number that best describes your activity level over the last 6 months. **Circle only ONE response.**
Regularly = once a week or more
Sometimes = once a month or less

10	I **regularly** participate in *impact sports* such as jogging, tennis, skiing, acrobatics, ballet, heavy labor, or backpacking.
9	I **sometimes** participate in *impact sports* such as jogging, tennis, skiing, acrobatics, ballet, heavy labor, or backpacking.
8	I **regularly** participate in *very active* events such as golf or bowling.
7	I **regularly** participate in *active* events such as bicycling.
6	I **regularly** participate in *moderate activities* such as swimming and unlimited housework or shopping.
5	I **sometimes** participate in *moderate activities* such as swimming and unlimited housework or shopping.
4	I **regularly** participate in *mild activities* such as walking, limited housework and limited shopping.
3	I **sometimes** participate in *mild activities* such as walking, limited housework and limited shopping.
2	I am **mostly** *inactive*: restricted to minimal activities of daily living.
1	I am **wholly** *inactive:* dependent on others; cannot leave residence.

SF-12 General Health

INSTRUCTIONS: For each of the following questions, please **circle** only one number on each line.

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor
1	2	3	4	5

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

		Yes, limited a lot	Yes, limited a little	No, not limited at all
a.	Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
b.	Climbing several flights of stairs	1	2	3

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3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	Accomplished less than you would like	1	2	3	4	5
b.	Were limited in the kind of work or other activities	1	2	3	4	5

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	Accomplished less than you would like	1	2	3	4	5
b.	Did work or other activities less carefully than usual	1	2	3	4	5

5. 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
1	2	3	4	5

6. These questions are about how you feel and how things have been with you 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…

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	Have you felt calm and peaceful?	1	2	3	4	5
b.	Did you have a lot of energy?	1	2	3	4	5
c.	Have you felt downhearted and depressed?	1	2	3	4	5

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

All of the time	Most of the time	Some of the time	A little of the time	None of the time
1	2	3	4	5

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Modified Harris Hip Score

For each category, check the box that best describes you: **(Please check only one box for each hip)**
R=Right Side L=Left Side

1. **Which of these categories would best describe your hip pain?**

R	L	
❑1	❑1	None/Able to ignore it
❑2	❑2	Slight, occasional, no compromise in activity
❑3	❑3	Mild, no effect on ordinary activity, pain after unusual activity, use aspirin/ibuprofen/Tylenol
❑4	❑4	Moderate, tolerable, make concessions, occasional pain reliever stronger than aspirin or Tylenol
❑5	❑5	Marked, serious limitations
❑6	❑6	Totally disabled

2. Functional capacity **(Please check only one box for each hip for each question below.)**

a. How much do you limp while walking?

R	L	
❑1	❑1	None
❑2	❑2	Slight
❑3	❑3	Moderate
❑4	❑4	Severe
❑5	❑5	Unable to walk

c. How far can you walk without stopping because of hip pain?

R	L	
❑1	❑1	Unlimited
❑2	❑2	6 Blocks
❑3	❑3	2-3 Blocks
❑4	❑4	Indoors only
❑5	❑5	Bed and chair only

e. How do you put on shoes and socks?

R	L	
❑1	❑1	With ease
❑2	❑2	With difficulty
❑3	❑3	Unable

b. Do you need support when walking?

R	L	
❑1	❑1	None
❑2	❑2	Cane for long walks
❑3	❑3	Cane all the time
❑4	❑4	Crutch
❑5	❑5	2 Canes
❑6	❑6	2 Crutches
❑7	❑7	Walker
❑8	❑8	Unable to walk

f. How long can you sit in a chair?

R	L	
❑1	❑1	Any chair, 1 hour
❑2	❑2	High chair, ½ hour
❑3	❑3	Unable to sit in any chair ½ hour

d. How do you go up and down stairs?

R	L	
❑1	❑1	Normally (1 foot on each step)
❑2	❑2	Normally with banister
❑3	❑3	Any method (Both feet on each step)
❑4	❑4	Not able

g. Are you able to use public transportation such as a bus or subway if you wanted to?

R	L	
❑1	❑1	Able to use
❑2	❑2	Unable to use

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HOOS

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 checking the appropriate box (only one box for each question.) If you are uncertain about how to answer a question, please give the best answer you can.

Symptoms
These questions should be answered thinking of your hip symptoms and difficulties during the **last week**.

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

Right Hip	❑1 Never	❑2 Rarely	❑3 Sometimes	❑4 Often	❑5 Always
Left Hip	❑1 Never	❑2 Rarely	❑3 Sometimes	❑4 Often	❑5 Always

S2. Difficulties spreading legs wide apart

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

S3. Difficulties to stride out when walking

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

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?

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

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

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

Pain
P1. How often is your hip painful?

Right Hip	❑1 Never	❑2 Rarely	❑3 Sometimes	❑4 Often	❑5 Always
Left Hip	❑1 Never	❑2 Rarely	❑3 Sometimes	❑4 Often	❑5 Always

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

P2. Straightening your hip fully

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

P3. Bending your hip fully

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

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P4. Walking on a flat surface

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

P5. Going up or down stairs

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

P6. At night while in bed

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

P7. Sitting or lying

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

P8. Standing upright

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

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

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

P10. Walking on an uneven surface

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

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

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A2. Ascending stairs

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A3. Rising from sitting

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A4. Standing

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

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

A5. Bending to the floor/pick up an object

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A6. Walking on a flat surface

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A7. Getting in/out of car

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A8. Going shopping

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A9. Putting on socks/stockings

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A10. Rising from bed

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A11. Taking off socks/stockings

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

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

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A13. Getting in/out of bath

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A14. Sitting

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A15. Getting on/off toilet

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

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

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

A17. Light domestic duties (cooking, dusting, etc)

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 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

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

SP2. Running

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

SP3. Twisting/pivoting on loaded leg

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

SP4. Walking on uneven surface

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

Quality of Life

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

Right Hip	❑1 Never	❑2 Monthly	❑3 Weekly	❑4 Daily	❑5 Constantly
Left Hip	❑1 Never	❑2 Monthly	❑3 Weekly	❑4 Daily	❑5 Constantly

Q2. Have you modified your life style to avoid activities potentially damaging

Right Hip	❑1 Not at all	❑2 Mildly	❑3 Moderately	❑4 Severely	❑5 Totally
Left Hip	❑1 Not at all	❑2 Mildly	❑3 Moderately	❑4 Severely	❑5 Totally

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

Right Hip	❑1 Not at all	❑2 Mildly	❑3 Moderately	❑4 Severely	❑5 Extremely
Left Hip	❑1 Not at all	❑2 Mildly	❑3 Moderately	❑4 Severely	❑5 Extremely

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

Right Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme
Left Hip	❑1 None	❑2 Mild	❑3 Moderate	❑4 Severe	❑5 Extreme

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Date of completion ___ / ___ / _____ **Case Identifier_____**
Revised 11.07.11 GB **Operative Side:** ☐ 1 **Left** ☐ 2 **Right**

EQ-5D Questionnaire

INSTRUCTIONS: Please answer the following questions to the best of your ability. Select the one answer that best describes your situation.

1. Are you having trouble with your other hip? ☐ Yes ☐ No

2. Do you for some other reason find it difficult to move? ☐ Yes ☐ No

3. **Mobility:**
☐ I have no problems walking
☐ I have some problems walking
☐ I am confined to bed

4**. Self-Care:**
☐ I have no problems with self care
☐ I have some problems washing or dressing myself
☐ I am unable to wash or dress myself

5. **Usual Activities:**
☐ I have no problems with performing my usual activities
☐ I have some problems with performing my usual activities
☐ I am unable to perform my usual activities

6. **Pain / Discomfort:**
☐ I have no pain or discomfort
☐ I have moderate pain or discomfort
☐ I have extreme pain or discomfort

7. **Anxiety / Depression:**
☐ I am not anxious or depressed
☐ I am moderately anxious or depressed
☐ I am extremely anxious or depressed

8. **Compared to my general health in the past 12 months, my health today is:**
☐ Better
☐ Unchanged
☐ Worse

http://dx.doi.org/10.2106/JBJS.15.00798

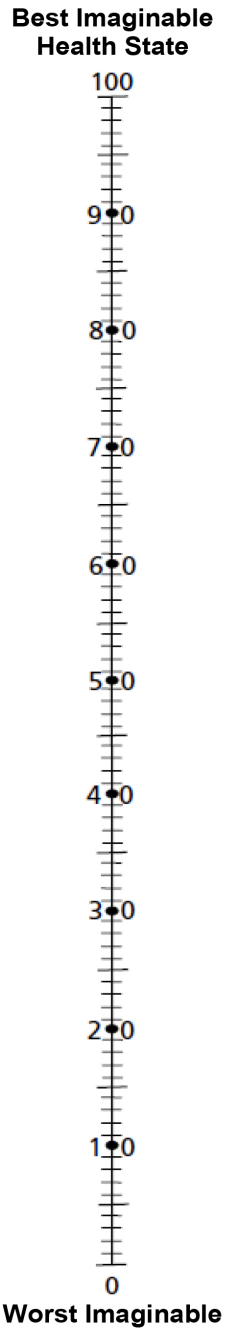
Date of completion ___ / ___ / _____ **Case Identifier_____**
Revised 11.07.11 GB **Operative Side:** ☐ 1 **Left** ☐ 2 **Right**

EQ VAS

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

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today



http://dx.doi.org/10.2106/JBJS.15.00798

Date of completion ___ / ___ / _____ **Case Identifier_____**

Revised 11.07.11 GB **Operative Side:** ☐ 1 **Left** ☐ 2 **Right**

Health State

Are you experiencing pain or limited function in any joint other than the surgical hip(s)? ❑1 Yes ❑2 No

If YES, specify joint(s) _____

Sports Participation

In the last 12 months did you participate in competitive sports? ❑1 Yes ❑2 No

(*Competitive sports defined as: **individual** sports, such as running, cycling or ice skating; **dual** sports, such as doubles tennis, and **team** sports competition, such as soccer, football, drill team, dance, or cheerleading)*

Please list the sport(s) *(i.e. soccer, ice skating, tennis etc.)* you participated in the last 12 months and level of participation.

❑ _____ ❑1 Elite ❑2 College ❑3 High School ❑4 Select/Travel ❑5 Junior High ❑6 Other _____

❑ _____ ❑1 Elite ❑2 College ❑3 High School ❑4 Select/Travel ❑5 Junior High ❑6 Other _____

❑ _____ ❑1 Elite ❑2 College ❑3 High School ❑4 Select/Travel ❑5 Junior High ❑6 Other _____

❑ _____ ❑1 Elite ❑2 College ❑3 High School ❑4 Select/Travel ❑5 Junior High ❑6 Other _____

POST-OPERATIVE PATIENTS ONLY

Are you satisfied with your hip surgery?

❑1 Yes ❑2 No

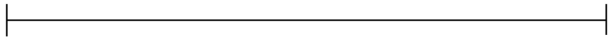
Please indicate how satisfied you are with your hip surgery:

❑1 Extremely Satisfied ❑2 Very Satisfied ❑3Satisfied ❑4 Somewhat Satisfied ❑5 Unsatisfied

If you could, would you choose *again* to have this surgery performed on your hip?

❑1 Yes ❑2 No

How would you rate your hip today as a percentage of normal (on a scale from 0% to 100%) with 100% being normal? (Please mark an "X" on the line below).



0% **100%**

http://dx.doi.org/10.2106/JBJS.15.00798

Date of completion ___ / ___ / _____ **Case Identifier_____**

Revised 2.2011 gb v3

Form completed by _____

Surgeon History and Diagnosis Form

Patient History

1. **Pain Location (check all that apply):**
___ 1 Anterior (groin)
___ 2 Lateral
___ 3 Posterior (buttock)
___ 4 Anterior Thigh
___ 5 Other _____

2. **Pain Chronicity:**
___1 < 6 Months
___2 6 Months – 1 Year
___3 > 1 Year – 3 Years
___4 > 3 Years – 5 Years
___5 >5 Years

3. **Charnley Classification**
___ 1 A (Unilateral joint, no other disability)
___ 2 B (Bilateral joint, no other disability)
___ 3 C (Unilateral or Bilateral with other joints or systemic diseases)

4. **Prior Hip Operations**: ☐1 Yes ☐ 2 No

If Yes, specify type and side:

Contralateral	Ipsilateral		Contralateral	Ipsilateral	
____1	____1	Bipolar/Unipolar Hemiarthroplasty	____27	____28	Proximal Femoral Osteotomy
____3	____4	Closed Reduction	____29	____30	Revision Acetabular Cup
____5	____6	Core Decompression	____31	____32	Revision Femoral Stem
____7	____8	Fusion	____33	____34	Revision THA
____9	____10	Girdlestone Resection Arthroplasty	____35	____36	SCFE In Situ Pinning
____11	____12	Hip Arthroscopy	____37	____38	Shelf Procedure
____13	____14	Limited Osteochondroplasty	____39	____40	Surgical Dislocation
____15	____16	Open Reduction/Capsulorrhaphy	____41	____42	Total Hip Replacement
____17	____18	ORIF Acetabular/Pelvic Fracture	____43	____44	Total Hip Resurfacing
____19	____20	ORIF Femoral Head Fracture	____45	____46	Trochanteric Advancement
____21	____22	ORIF Intertrochanteric Fracture	____47	Contralateral Other _____	
____23	____24	ORIF Other Femur Fracture	____48	Ipsilateral Other _____	
____25	____26	Pelvic Osteotomy			

Preoperative Diagnosis

JOINT PRESERVATION (NON-ARTHROPLASTY)

___1 Pre- or early arthritic Hip Disease Etiology:
- ___1 DDH
- ___2 SCFE
- ___3 Perthe's
- ___4 Chondrolysis
- ___5 FAI CAM
- ___6 FAI Pincer
- ___7 FAI Combined
- ___9 Internal Derangement (Labral Tear, Chondral Flap, Synovitis, Etc.)
- ___8 Other _____

___2 Acute Fracture
___3 Osteonecrosis
___4 Post–Traumatic Arthritis
___5 Rheumatoid Arthritis
___6 Other:_____

HIP ARTHROPLASTY

___7 Secondary Osteoarthritis Etiology:
- ___1 DDH
- ___2 SCFE
- ___3 Perthe's
- ___4 Chondrolysis
- ___5 FAI CAM
- ___6 FAI Pincer
- ___7 FAI Combined
- ___8 Too Far Advanced to Determine
- ___9 Other _____

___8 Failed THA–Aseptic Loosening
___9 Failed THA–Septic Loosening
___10 Failed THA–Instability
___11 Failed THA–Wear/ Lysis/ Breakage
___12 Failed ORIF

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Form completed by:_____

Surgeon Evaluation Form

Physical Exam

1. Height: _____cm

2. Weight: _____kg

3. Limp upon examination:

☐[1] None ☐[2] Slight ☐[3] Moderate

☐[4] Severe ☐[5] Unable to Walk

4. Standing Trendelenberg Test:

Right Hip: ☐[1] Positive ☐[2] Negative ☐[3] Unable to test

Left Hip: ☐[1] Positive ☐[2] Negative ☐[3] Unable to test

5. Leg Length Discrepancy:

☐[1]Legs Equal ☐[2] Left Short ☐[3] Right Short

True Discrepancy: _____cm

6. Skin Status:

☐[1] Normal
☐[2] Previous Incision
☐[3] Healed (Index Procedure)

7. Range of Motion:	**Right**	**Left**
Start of Flexion:	_____°	_____°
End of Flexion:	_____°	_____°
IR @ 90° Flexion:	_____°	_____°
ER @ 90° Flexion:	_____°	_____°
Abduction:	_____°	_____°
Adduction:	_____°	_____°
ERE:	_____°	_____°
IRE:	_____°	_____°

8. Anterior Impingement:

Right Hip: ☐[1] **-** ☐[2] **+**

Left Hip: ☐[1] **-** ☐[2] **+**

9. Apprehension/ Posterior Impingement Test (Supine):

Right Hip: ☐[1] **-** ☐[2] **+**

If + { ☐[1] Anterior Apprehension (groin) ; ☐[2] Posterior Impingement Pain (buttock) }

Left Hip: ☐[1] **-** ☐[2] **+**

If + { ☐[1] Anterior Apprehension (groin) ; ☐[2] Posterior Impingement Pain (buttock) }

10. Neurological Status Intact:

☐[1] Yes ☐[2] No

If No, Specify Neurological Status Not Intact:

_____

11. Abductor Strength:

Right	**Left**
☐[1] 5/5	☐[1] 5/5
☐[2] 4/5	☐[2] 4/5
☐[3] 3/5	☐[3] 3/5
☐[4] 2/5	☐[4] 2/5
☐[5] 1/5	☐[5] 1/5
☐[6] 0/5	☐[6] 0/5

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Radiographic Findings (Digital Measurements)

(1) Anteroposterior Pelvis: ☐1Standing ☐2Supine

1. Date of X-Ray: _____

2. Pelvic Tilt (distance from Symphysis to SC junction): _____mm

_____ Unable to assess

3. Pelvic Rotation (distance from Symphysis Trajectory to Middle of Sacrum): _____mm

_____ Unable to assess

4. Tonnis Classification:

___1 **Grade 0** (no signs of osteoarthritis)

___2 **Grade 1** (increased sclerosis of the head and acetabulum)

___3 **Grade 2** (small cysts in the head or acetabulum, moderate joint space narrowing, moderate loss of head sphericity)

___4 **Grade 3** (large cysts in head or acetabulum, severe joint space narrowing or obliteration, severe deformity of femoral head, evidence of necrosis)

5. Minimum Joint Space Width (AP Pelvis): _____mm

6. Lateral Center-Edge Angle (Wiberg): _____ deg.

7. Acetabular Inclination (Tonnis angle): _____ deg.

8. Cross Over Sign: ☐1 **Yes** ☐2 **No**

If Yes, Crossover Location: ☐1 **Superior 1/3 of Acetabulum**
☐2 **Middle 1/3 of Acetabulum**
☐3 **Inferior 1/3 of Acetabulum**

9. Posterior Wall Sign: ☐1 **Yes** ☐2 **No**

10. Prominence of the Ischial Spine (PRIS) Sign: ☐1 **Yes** ☐2 **No**

11. α Angle: _____°

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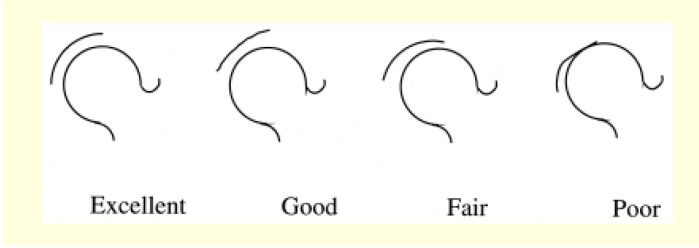
12. Femoral Head—Neck Offset: ☐1 **Normal** ☐2 **Mild Deformity (Flat or Slight Concavity)** ☐3 **Deformity (Convexity)**

13. Joint Congruity (Yasunaga et al., 2003): (select most appropriate representation)

☐1 **Excellent** ☐2**Good** ☐3 **Fair** ☐4 **Poor**



(2) Abduction/Flexion/IR Functional View: ☐1Yes ☐2No

14. Date of X-Ray: _____

15. Joint Congruity: (select most appropriate representation)

☐1 **Excellent** ☐2**Good** ☐3 **Fair** ☐4 **Poor**

16. Minimum Joint Space Width: _____mm

(3) Faux Profile View: ☐1Yes ☐2No

17. Date of X-Ray: _____

18. ACE Angle: _____°

(4) Frog Lateral View: ☐1Yes ☐2No

19. Date of X-Ray: _____

20. α Angle: _____°

21. Femoral Head—Neck Offset: ☐1 **Normal** ☐2 **Mild Deformity (Flat or Slight Concavity)** ☐3 **Deformity (Convexity)**

http://dx.doi.org/10.2106/JBJS.15.00798

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(5) Dunn View: ☐1Yes ☐2No

22. Date of X-Ray: _____

23. α Angle: _____°

24. Femoral Head—Neck Offset: ☐1 **Normal** ☐2 **Mild Deformity (Flat or Slight Concavity)** ☐3 **Deformity (Convexity)**

(6) True Lateral (15° IR): ☐1Yes ☐2No

25. Date of X-Ray: _____

26. α Angle: _____°

27. Femoral Head—Neck Offset: ☐1 **Normal** ☐2 **Mild Deformity (Flat or Slight Concavity)** ☐3 **Deformity (Convexity)**

(7) MRI Study: ☐1Yes ☐2No

28. Date of MRI Study: _____

29. MRI Field Strength: _____ Tesla

30. Radial Imaging: ☐1 **Yes** ☐2 **No**

31. Contrast: ☐1 **None** ☐2 **Intra-articular** ☐3 **Intra-venous**

32. Biochemical Imaging: ☐1 **None** ☐2 **dGEMRIC** ☐3 **T1rho** ☐4 **T2** ☐4 **gagCEST**

33. Labral Tear (full thickness): ☐1 **Yes** ☐2 **No**

34. Acetabular Cyst: ☐1 **Yes** ☐2 **No**

35. Femoral Head Cyst: ☐1 **Yes** ☐2 **No**

36. Alpha Angle: ☐1 **Yes** ☐2 **No (*Skip to* question #43)**

37. Alpha Angle Measurement Image Type: ☐1 **Oblique Axial** ☐2 **Radial 2 o'clock**

38. Alpha Angle Measurement:

Oblique Axial: _____°

Radial 2 o'clock: _____°

(8) CT Scan: ☐1Yes ☐2No

42. Date of CT Scan: _____

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Form completed by _____

Surgical Procedure

Surgeon: _____

1. **Date of Surgery** M M D D Year ☐☐ ☐☐ ☐☐☐☐

2. **Hip Operated On** ☐ 1 Right ☐ 2 Left

3. **Which procedures were performed** (check all procedures performed):

___1 Acetabular articular cartilage grafting
___2 Acetabular articular cartilage fixation
___3 Acetabular chondroplasty
___4 Acetabular microfracture
___5 Acetabular rim osteoplasty
___6 Adhesiolysis-head neck junction
___7 Adhesiolysis-labrocapsular junction
___8 Arthroscopy
___9 Arthroscopic partial capsulectomy
___10 Arthroscopic capsular incision/closure (longitudinal)
___11 Capsular Tightening
___12 Femoral head articular cartilage fixation
___13 Femoral head articular grafting
___14 Femoral head central resection
___15 Femoral head chondroplasty
___16 Femoral head microfracture
___17 Femoral intertrochanteric osteotomy
___18 Femoral neck lengthening (relative)
___19 Femoral head/ neck osteochondroplasty
___20 Femoral neck osteotomy
___21 Labral reconstruction (graft)
___22 Labral recontouring/ shrinkage/thermal stabilization
___23 Labral refixation/ repair
___24 Labral resection (partial)
___25 Labral resection (complete)
___26 Ligamentum teres debridement
___27 Ligamentum teres repair
___28 Open arthrotomy
___29 ORIF SCFE
___30 Periacetabular osteotomy
___31 Primary total hip replacement
___32 Psoas lengthening/ Release
___33 Revision hip arthroplasty
___34 Surgical hip dislocation
___35 Synovectomy
___36 Total hip resurfacing
___37 Trochanteric advancement
___38 Trochanteric osteoplasty
___39 Other: _____

4. **Surgical Approach** (open hip procedures)
   - ☐1 Anterior (Smith-Petersen/ Hueter Interval)
   - ☐2 Anterolateral
   - ☐3 Arthroscopic
   - ☐4 Lateral (transtrochanteric)/ Surgical Dislocation
   - ☐5 Posterior/ Posterolateral
   - ☐6 Other

5. **Procedure 1:**
   Estimated Blood Loss _____ cc

   Duration of Surgery from skin incision to skin closure: _____ min.

6. **Procedure 2:**
   Estimated Blood Loss _____ cc

   Duration of Surgery from skin incision to skin closure: _____ min.

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Surgical Findings

7. **ACETABULAR ARTICULAR CARTILAGE**

☐ 1 **Visualize** ☐ 2 **Partially Visualize** ☐ 3 **Not Able to Visualize (*Skip to* Femoral Head)**

8. Chondromalacia (cartilage abnormality):

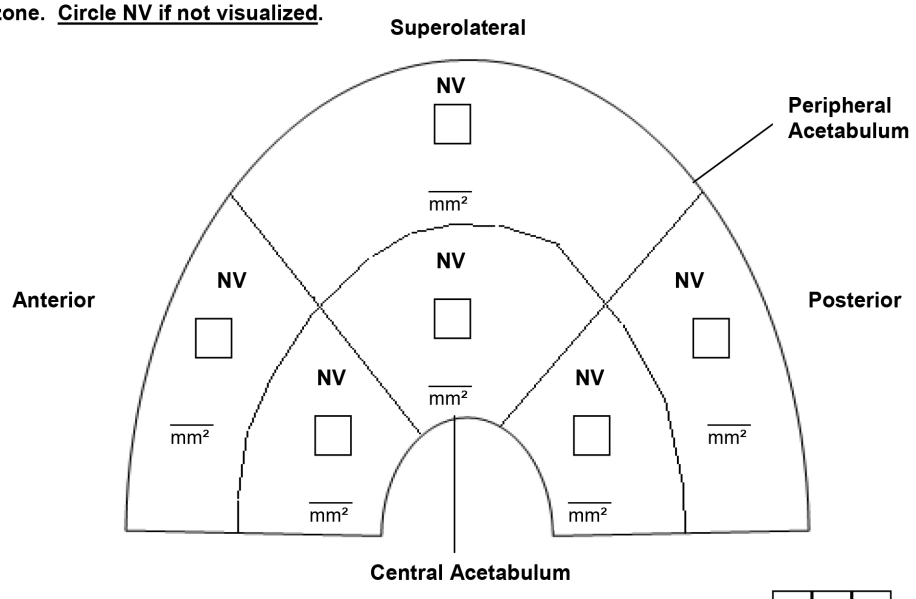
☐ 1 Yes ☐ 2 No **Classification (most severe disease) (**Beck et al., 2005, Br JBJS)

___1 Normal (Macroscopically sound cartilage)
___2 Malacia (Roughening of surface, fibrillation)
___3 Debonding (Loss of fixation to the subchondral bone, macroscopically sound cartilage; carpet phenomenon)
___4 Cleavage (Loss of fixation to the subchondral bone; frayed edges, thinning of the cartilage, flap)
___5 Defect (Full-thickness defect, complete loss of cartilage)

9. Treatment for Chondromalacia:

___1 None
___2 Abrasion arthroplasty
___3 Allograft
___4 Cell transplant
___5 Chondroplasty (debride loose articular cartilage only)
___6 Implant fixation ("dart"/screw)
___7 Microfracture with chondroplasty
___8 Microfracture without chondroplasty
___9 Mosaicplasty
___10 Prosthetic Replacement procedure
___11 Thermal Treatment
___12 Other _____

Mark the WORST classification Chondromalacia of each zone involved. Please enter the grade of chondromalacia in each zone using the 1, 2, 3, 4, 5 grading system. If a section is normal, please grade as 1. Estimate lesion size for each zone. Circle NV if not visualized.



10. If "Full Thickness Defect," what percent of acetabular surface is involved? ☐☐☐ .0%

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(Estimate total acetabular surface area involvement)

11. FEMORAL HEAD ARTICULAR CARTILAGE

☐ 1 **Visualize** ☐ 2 **Partially Visualize** ☐ 3 **Not Able to Visualize (*Skip* to Acetabular Labrum**

12. Chondromalacia (cartilage abnormality):

☐ 1 Yes ☐ 2 No

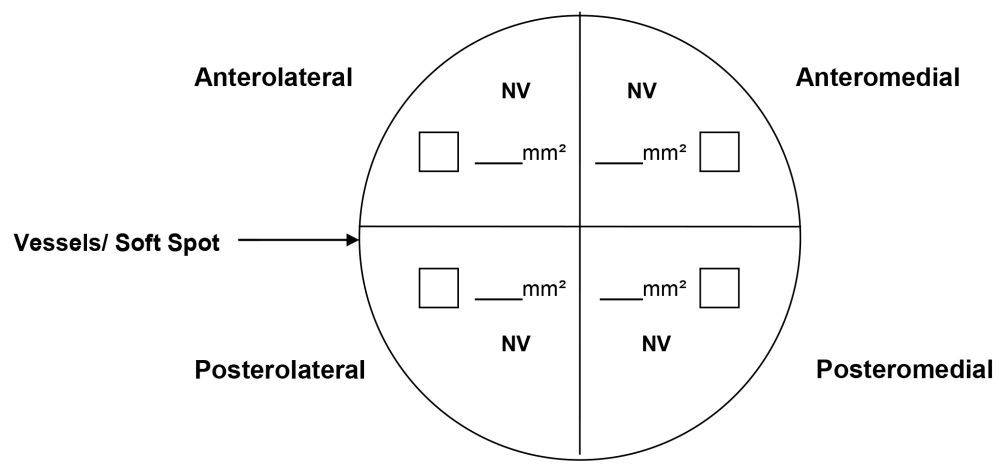
Classification (most severe disease) (Beck et al., 2005, Br JBJS)

___1 Normal (Macroscopically sound cartilage)
___2 Malacia (Roughening of surface, fibrillation)
___3 Debonding (Loss of fixation to the subchondral bone, macroscopically sound cartilage; carpet phenomenon)
___4 Cleavage (Loss of fixation to the subchondral bone; frayed edges, thinning of the cartilage, flap)
___5 Defect (Full-thickness defect, complete loss of cartilage)

13. Treatment for Chondromalacia:

___1 None
___2 Abrasion arthroplasty
___3 Allograft
___4 Cell transplant
___5 Chondroplasty (debride loose articular cartilage only)
___6 Implant fixation ("dart"/screw)
___7 Microfracture with chondroplasty
___8 Microfracture without chondroplasty
___9 Mosaicplasty
___10 Prosthetic Replacement procedure
___11 Thermal Treatment
___12 Other _____

Mark the WORST classification Chondromalacia of each section involved. Please enter the grade of chondromalacia in each zone using the 1, 2, 3, 4, 5 grading system. If a section is normal, please grade as 1. Estimate lesion size for each zone. Circle NV if not visualized.



14. If "Full Thickness Defect," what percent of femoral head surface is involved? ☐☐☐ .0%

(Estimate total acetabular surface area involvement)

http://dx.doi.org/10.2106/JBJS.15.00798

Date of completion ___ / ___ / _____ **Case Identifier_____**
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15. ACETABULAR LABRUM

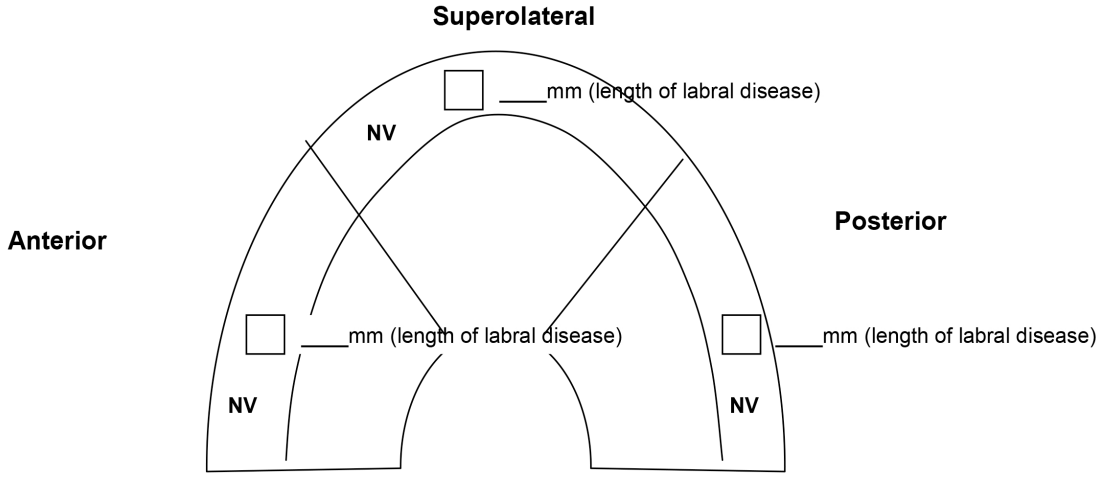
☐ 1 **Visualize** ☐ 2 **Partially Visualize** ☐ 3 **Not Able to Visualize (*Skip* to Femoral-Head Neck Junction)**

16. Labral Disease:

☐ 1 Yes ☐ 2 No **Classification (most severe disease) (**Beck et al., 2004, Br JBJS)

___1 Normal (Macroscopically sound labrum)
___2 Degeneration (Thinning or localized hypertrophy, fraying, discoloration)
___3 Full-thickness tear (Complete avulsion from the acetabular rim)
___4 Detachment (Separation between acetabular and labral cartilage,preserved attachment to bone)
___5 Ossification (Osseous metaplasia, localized or circumferential)

Mark the WORST classification of labral disease for each section involved. Please enter the classification of labral disease in each zone using the 1, 2, 3, 4, 5 grading system. If a section is normal, please grade as 1. Estimate lesion size for each zone. Circle NV if not visualized.



17. Morphology:

___1 Normal
___2 Hypoplastic
___3 Hypertrophic
___4 Ossified
___5 Not visualized

18. Previous labral surgery:

___1 No
___2 Partial Resection
___3 Full Resection
___4 Repair
___5 Graft

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19. FEMORAL HEAD – NECK JUNCTION

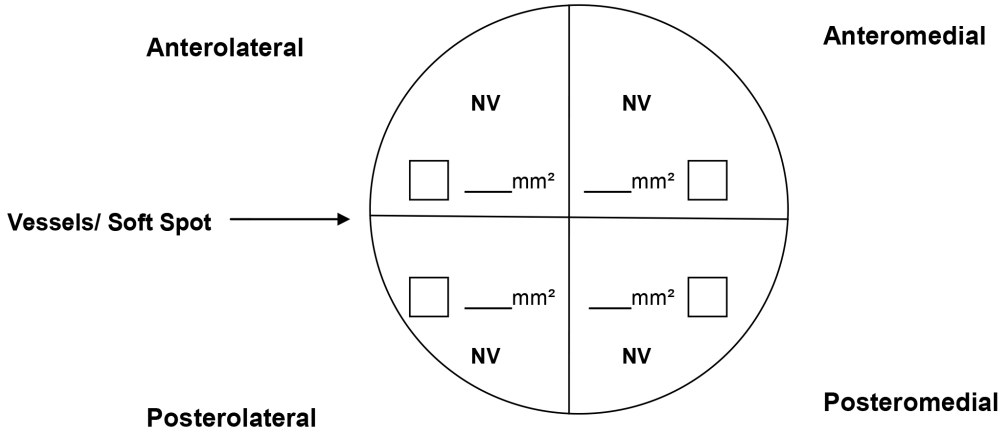
☐ 1 **Visualize** ☐ 2 **Partially Visualize** ☐ 3 **Not Able to Visualize (*Skip* to Item #25)**

20. Chondromalacia (cartilage abnormality):

☐ 1 Yes ☐ 2 No **Classification (most severe disease) (**Beck et al., 2005, Br JBJS)

___1 Normal (Macroscopically sound cartilage)
___2 Malacia (Roughening of surface, fibrillation)
___3 Debonding (Loss of fixation to the subchondral bone, macroscopically sound cartilage; carpet phenomenon)
___4 Cleavage (Loss of fixation to the subchondral bone; frayed edges, thinning of the cartilage, flap)
___5 Defect (Full-thickness defect, complete loss of cartilage)

Mark the WORST classification Chondromalacia of each section involved. Please enter the grade of chondromalacia in each zone using the 1, 2, 3, 4, 5 grading system. If a section is normal, please grade as 1. Estimate lesion size for each zone. Circle NV if not visualized.



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21. Previous Osteochondroplasty: ☐1 Yes ☐2 No

If YES, residual osteochondral prominence? ☐1 Yes ☐2 No

If YES, which zone(s)?
___1 Anterolateral
___2 Anteromedial
___3 Posterolateral
___4 Posteromedial

22. Osteochondral prominence/ Reduced Offset: ☐1 Yes ☐2 No

If YES, which zone(s)?
___1 Anterolateral
___2 Anteromedial
___3 Posterolateral
___4 Posteromedial

23. Impingement trough: ☐1 Yes ☐2 No

If YES, which zone(s)?
___1 Anterolateral
___2 Anteromedial
___3 Posterolateral
___4 Posteromedial

24. Femoral neck osteophyte: ☐1 Yes ☐2 No

If YES, which zone(s)?
___1 Anterolateral
___2 Anteromedial
___3 Posterolateral
___4 Posteromedial

25. Ligamentum Teres:
☐1 Intact
☐2 Fraying/ Partial Tear
☐3 Complete Tear
☐4 Previous Surgical Release
☐5 Not able to visualize
☐6 Absent

26. Synovitis: ☐1 Yes ☐2 No

27. Capsule:
☐1 Atrophic
☐2 Normal
☐3 Hypertrophic/tight
☐4 Lax/Redundant

28. Loose Bodies: ☐1 Yes ☐2 No

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Date of completion ___ / ___ / _____ **Case Identifier_____**
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Postoperative Care

21. DVT Prophylaxis:

☐1 ASA
☐2 Compression stockings
☐3 Coumadin
☐4 LMWH
☐5 Mechanical compression device (foot/compression boots)
☐6 None

22. Physical Therapy

CPM: ☐1 Yes ☐2 No

Weight bearing:

☐1 NWB
☐2 TTWB
☐3 30%
☐4 50%
☐5 FWB

Estimated Time to full weight bearing:

☐1 Immediate
☐2 4 Weeks
☐3 8 Weeks
☐4 12 Weeks
☐5 Other_____

Heterotopic Ossification Prophylaxis: ☐1 Yes ☐2 No

If YES, specify:

☐1 Indocin
☐2 Naprosyn
☐3 XRT
☐4 Other _____

Hip Abduction Brace: ☐1 Yes ☐2 No

Hip Precautions: ☐1 Yes ☐2 No

If YES, specify:

☐1 Anterior
☐2 Posterior
☐3 Global

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Date of completion ___ / ___ / _____ **Case Identifier:**
Revision 7.26.10 **Date of Surgery:**
Form completed by:

Adverse Events / Complications/ Reoperations

Surgeon _____

1. Any post-operative complications in surgical hip? ☐1 **Yes** ☐2 **No**

2. Complication(s) Description:

Grade 1 (trivial)= A complication that requires no treatment and has no clinical relevance, there is no deviation from routine follow-up during the post-operative period. Allowed therapeutic regimens include: antiemetics, antipyretics, analgetics, diuretics, electrolytes, antibiotics, and physiotherapy
Grade 2 (moderate)= A deviation from the normal post-operative course (including unplanned clinic visits) that requires outpatient treatment either pharmacological or close monitoring as an outpatient.
Grade 3 (severe) = A complication that is treatable but requiring surgical, endoscopic, radiologic interventions or an unplanned hospital admission.
Grade 4 (severe)= A complication that is life threatening, requires ICU admission, or that is not treatable with potential for permanent disability. Complications requiring organ resection (THA).
Grade 5 (death)= Death

	Check all that apply:	Complication Grade:
AVN	_____1	_____
DVT	_____2	_____
Dislocation	_____3	_____
Pulmonary Embolism		_____
Fracture—intra-articular	_____4	_____
Fracture—posterior column	_____5	_____
Fracture—other	_____6	_____
Heterotopic Ossification (Brooker Grade)	_____7	_____
___ Grade I (Islands of bone within the soft tissues about the hip)		
___ Grade II (bone spurs leaving ≥1cm between opposing bone surfaces)		
___ Grade III (bone spurs leaving <1cm between opposing bone surfaces)		
___ Grade IV (Apparent bone ankylosis of the hip)		
Implant Failure	_____8	_____
Infection—Superficial	_____9	_____
Infection—Deep	_____10	_____
Major Nerve Palsy / Injury	_____11	_____
___ Femoral		
___ Peroneal		
___ Sciatic		
Non-Union	_____12	_____
___ Ilium		
___ Ischium		
___ Pubis		
___ Trochanter		
Sensory Nerve Dysesthesia (Pain- LFCN)	_____14	_____
Wound Dehisence	_____15	_____
Wound Hematoma	_____16	_____
Other _____	_____17	_____

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Date of completion ___ / ___ / _____ **Case Identifier:**
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3. Treatment:

_____
_____
_____
_____

3. **Any reoperations on the surgical hip (at any time point)?** ☐1 **Yes** ☐2 **No**

	Performed?		Date		
	Yes	**No**	**M**	**D**	**Year**
Arthroscopy	☐1	☐2	___ /	___ /	_____
Hardware Removal	☐1	☐2	___ /	___ /	_____
Heterotopic Bone Excision	☐1	☐2	___ /	___ /	_____
Hip Replacement	☐1	☐2	___ /	___ /	_____
Trochanteric ORIF	☐1	☐2	___ /	___ /	_____
Wound I&D	☐1	☐2	___ /	___ /	_____
Other Reoperations (Specify Other Reoperations):	☐1	☐2	___ /	___ /	_____
_____	☐1	☐2	___ /	___ /	_____
_____	☐1	☐2	___ /	___ /	_____
_____	☐1	☐2	___ /	___ /	_____

4. Outcome:
- ☐1 Healed/Resolved
- ☐2 Permanent disability:_____
- ☐3 Death

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Date of completion ___ / ___ / _____ **Case Identifier:**
Revision 7.26.10 **Date of Surgery:**

Adverse Event Form

General Guidance:

Report adverse events, product problems or product use errors with:

- **Medications**
- **Medical devices**
- **Combination products**
- **Human cells, tissues and cellular and tissue-based products**

Report SERIOUS adverse events. An event is serious when the patient outcome is:

- **Death**
- **Life-threatening**
- **Hospitalization**
- **Disability or permanent damage**
- **Required intervention to prevent permanent impairment or damage**
- **Other serious (important medical events)**

(1) Adverse Event, Product Problem, or Error (check all that apply):

___1 Adverse Event ___3 Product Problem
___2 Product Use Error ___4 Problem with Different Manufacturer of Same Device

Outcomes attributed to Adverse Event (check all that apply):

_____1 Death: _____ _____
(mm/dd/yyyy)
_____2 Disability or Permanent Damage
_____3 Hospitalization – initial or prolonged
_____4 Life-threatening
_____5 Other Serious (Important medical events)
_____6 Required Intervention to Prevent Permanent Impairment or Damage

1. Date of Event **M M D D Y Y Y Y** ☐☐ ☐☐ ☐☐☐☐
2. Date of this Report **M M D D Y Y Y Y** ☐☐ ☐☐ ☐☐☐☐
3. Describe Event, Problem, or Product Use Error

_____
_____
_____
_____
_____
_____

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Date of completion ___ / ___ / _____
Revision 7.26.10

Case Identifier:
Date of Surgery:

4. Relevant Tests/Laboratory Data, Including Dates

_____
_____
_____
_____
_____
_____

5. Other **Relevant** History, Including Preexisting Medical Conditions (e.g. allergies, race, pregnancy, smoking and alcohol use, liver/kidney problems, etc.)

_____
_____
_____
_____
_____
_____

(2) Suspect Products

1. Brand Name _____
2. Common Device Name _____
3. Manufacturer Name, City and State _____
4. Model # _____ Lot # _____

   Catalog # _____ Expiration Date _____

   Serial # _____ Other # _____
5. If implanted, give date **M M** ☐☐ **D D** ☐☐ **Y Y Y Y** ☐☐☐☐
6. If explanted, give date **M M** ☐☐ **D D** ☐☐ **Y Y Y Y** ☐☐☐☐
7. Is this a single-use device that was reprocessed and reused on a patient?
   ☐ 1 **Yes** ☐ 2 **No**

   If YES, enter name and address or reprocessor

   _____
   _____
   _____