OXFORD HIP SCORE

Patient Name _____

Date of Birth _____

Hospital Number _____

Date of Consultation ____/____/_____

□ BRI □ Nuffield □ YC

□ Left □ Right

□ Primary THR □ Revision THR

□ Preop □ 3 month □ 1 year

□ 5 year □10 year

The following questions must ALL be answered on your **experiences over the past 4 weeks**

1 How would you describe the pain you usually have in your hip?

L	R	
O	O	None
O	O	Very Mild
O	O	Mild
O	O	Moderate
O	O	Severe

2 Have you had any trouble with washing and drying yourself (all over) because of your hip?

L	R	
O	O	No trouble at all
O	O	Very little trouble
O	O	Moderate trouble
O	O	Extreme difficulty
O	O	Impossible to do

3 Have you had any trouble getting in and out of a car or using public transport because of your hip? (with or without a stick)

L	R	
O	O	No trouble at all
O	O	Very little trouble
O	O	Moderate trouble
O	O	Extreme difficulty
O	O	Impossible to do

4 Have you been able to put on a pair of socks, stockings or tights

L	R	
O	O	Yes,easily
O	O	With little difficulty
O	O	With moderate difficulty
O	O	With extreme difficulty
O	O	No, impossible

5 Could you do the household shopping on your own?

L	R	
O	O	Yes, easily
O	O	With little difficulty
O	O	With moderate difficulty
O	O	With extreme difficulty
O	O	No, impossible

6 For how long have you been able to walk before the pain in your hip becomes severe (with or without a stick)

L	R	
O	O	No pain for 30 minutes or more
O	O	16-30 minutes
O	O	5 to 15 minutes
O	O	Around the house only
O	O	Not at all

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7 Have you been able to climb a flight of stairs?

L	R	
O	O	Yes, easily
O	O	With little difficulty
O	O	With moderate difficulty
O	O	With extreme difficulty
O	O	No, impossible

8 After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your hip?

L	R	
O	O	Not at all painful
O	O	Slightly painful
O	O	Moderately painful
O	O	Very painful
O	O	Unbearable

9 Have you been limping when walking because of your hip?

L	R	
O	O	Rarely / never
O	O	Sometimes or just at first
O	O	Often, not just at first
O	O	Most of the time
O	O	All of the time

10 Have you had any sudden, severe pain (shooting, stabbing or spasms) from your affected hip?

L	R	
O	O	No days
O	O	Only 1 or 2 days
O	O	Some days
O	O	Most days
O	O	Every day

11 How much has pain from your hip interfered with your usual work, including housework?

L	R	
O	O	Not at all
O	O	A little bit
O	O	Moderately
O	O	Greatly
O	O	Totally

12 Have you been troubled by pain from your hip in bed at night?

L	R	
O	O	No nights
O	O	Only 1 or 2 nights
O	O	Some nights
O	O	Most nights
O	O	Every night

Thank you for taking the time to complete this questionnaire.

Please return this to the nurse helping in my clinic

Reference for Oxford Hip Score:
Dawson J, Fitzpatrick R, Carr A, Murray D.
Questionnaire on the perceptions of patients about total hip replacement. *J Bone Joint Surg [Br]* 1996;78-B:185–90

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