

HIP FOLLOWUP PHYSICAL EXAM

Thomas P. Gross M.D
Midlands Orthopaedics
1910 Blanding St
Columbia SC 29201

<p>Office Use Only</p> <p>Date Received: ____/____/____</p> <p>Office Record Number: _____</p>

Name of patient being evaluated: _____

Date of Surgery: Right: _____ Left: _____

Type of Surgery: Right: _____ Left: _____

Interval from Surgery:

- | | |
|------------|-----------|
| Right: N/A | Left: N/A |
| 6 weeks | 6 weeks |
| 1 year | 1 year |
| 2 year | 2 year |
| Or _____ | Or _____ |

TO BE COMPLETED BY A PHYSICAL THERAPIST

- 1. Patient Charnley Category:**
 A1: Unilateral with opposite hip normal
 A2: Bilateral with satisfactory function of opposite hip
 B: Unilateral other hip impaired __
 C: Multiple arthritis or medical infirmity

2. Range of Motion:	Right	Left
a. Flexion Contracture*	_____	_____
b. Flexion to**	_____	_____
c. abduction at 45 degees of flexion to	_____	_____
d. adduction at 45 degrees of flexion to	_____	_____
e. external rotation at 45 degrees of flexion to	_____	_____
f. internal rotation at 45 degrees of flexion to	_____	_____
g. IR with knee flexed to 90 degrees ***	_____	_____

* Enter 0 if the leg is able to lie flat on the exam table.
 ** Do not push past 100 degrees before 1 year
 ***Do not perform this one until one year after surgery please

- 3. Gait:**
- Normal
 - Antalgic
 - Trendelenburg
 - Short Leg
 - Other _____

4. Trendelenburg Sign:

- Positive
 - Negative
- 5. Active SLR painful?**
- No
 - Yes If Yes Where? _____
- 6. Strength SLR (grade 0-5):** _____
- 7. Strength Abduction (grade 0-5):** _____
- 8. Leg Length:**
Equal Left short _____ Right short _____
- 9. Tender:**
- No
 - Yes If yes, where? _____
- 10. Condition of incision:** _____

Physical Therapist Signature:

Date: _____

Print Name: _____

Address: _____

Please give a copy to the patient and mail one to me at the above address. Thank you.

Updated 1/31/08