



Hip Follow-Up

1-Year Interval

It is important to review the status of your hip implant(s) during an office visit at **six weeks, one year, two years, and every other year postoperatively thereafter** even if you are feeling great. Long distance follow-up evaluations for out-of- state patients are fine. We would like to ask you to complete the following evaluation protocol.

Summary of this Follow-Up

1. Hip questionnaire (pg 3): We keep track of each joint separately in our database. Therefore, I would like to request that you fill out a self rating form for EACH hip, even if both are identical. Please send to us.
2. Physical Therapy (pg 7):
 - a. Add your name to the physical therapy evaluation request
 - b. Give the order and physical exam form to your physical therapist
 - c. Send the results to us
3. Hip X-Ray (pg 9):
 - a. Add your name and DOB to the x-ray request
 - b. Have the x-ray of your hip(s) done at your local hospital or freestanding imaging facility and request a CD copy of this x-ray be sent to us.

As soon as we receive all of the above, Dr. Gross will review them and send you a written response. If you prefer to travel here for an office visit for evaluation, please call our appointment line to arrange this (803)-256-4107 (*routine office charges will apply*). If you are having significant problems with your hip, I will need to see you in the office for complete examination to best diagnose it.

Thank you for your attention to this matter. If you have any questions, please contact us for assistance.

Thomas P. Gross, MD

Lee Webb, DNP, APRN, FNP-C



Hip Follow-Up

1-Year Interval

Attached Forms

1. Hip questionnaire (pg 3)
2. Physical Exam (pages 7-8)
 - a. PT eval letter and order (page 7)
 - b. Physical exam form (page 8)
3. X-ray order forms (pages 9)

Have any questions? Contact us for follow-up assistance at:

E-mail: grosspatientfollowup@midlandsortho.com | Phone: (803) 933-6127

After you've completed your (1) questionnaire, (2) physical exam, and (3) x-rays, please FEDEX these materials to:

Dr. Thomas P. Gross
Attn: Hip follow-up
Midlands Orthopaedics & Neurosurgery
1910 Blanding St.
Columbia, SC 29201

HIP FOLLOW-UP

QUESTIONNAIRE

PERSONAL INFORMATION

Please provide up-to-date contact information.

Full Name :

Primary Phone : Current Date :
D D M M Y Y

Full Address :

E-Mail :

FOLLOW-UP INFORMATION

1. Where was this form completed?

☐ Office ☐ Phone ☐ Mail-In ☐ Internet

2. This questionnaire is for the evaluation of my (side) hip.

☐ Left ☐ Right

3. I have had problems with my (side) hip(s).

☐ Left ☐ Right ☐ Both

4. Dr. Gross has operated on my (side) hip(s).

☐ Left ☐ Right ☐ Both

5. Another surgeon has operated on my (side) hip(s).

☐ Left ☐ Right ☐ Both

6. Dr. Gross performed the followed operation(s) on me:

☐ Total hip replacement ☐ Hip resurfacing ☐ Revision hip surgery

☐ Other:

COMPLICATIONS

1. List any complications you had post-surgery:

☐ None ☐ Wound Infection ☐ Deep Venous Thrombosis ☐ Dislocation ☐ Fracture
☐ Loose Implant ☐ Pulmonary Embolus ☐ Partial Sciatic Palsy ☐ Other:

2. Did you have any complications that required further surgery?

☐ Yes | Please explain:

☐ No

HIP FOLLOW-UP

QUESTIONNAIRE

CLINICAL FUNCTION SCORE

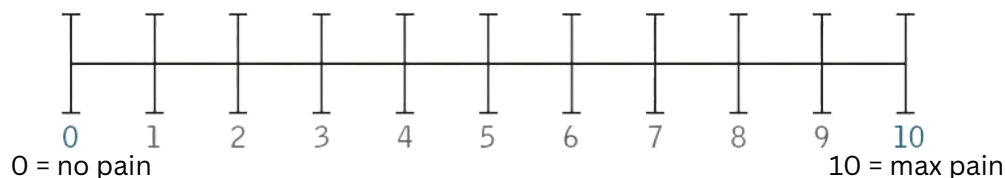
1. What category most closely represents your pain level?

- ☐ None, or so insignificant that I ignore it
- ☐ Regularly slight
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Disabled

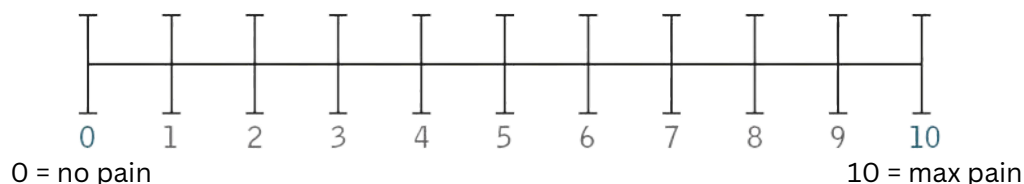
2. My hip pain is located in my (check all that apply):

- ☐ No pain
- ☐ Groin
- ☐ Buttock
- ☐ Front of thigh
- ☐ Side of thigh
- ☐ Side of hip, near scar
- ☐ Other pain: _____

3. Please circle your regular pain level on the following scale.



4. Please circle your highest hip pain level on the following scale.



5. Please indicate the severity of your limp, if any.

- ☐ None
- ☐ Slight
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Disabled

6. Please indicate your use of support, if any.

- ☐ None required
- ☐ Use of a cane or a stick for long walks or high activity only
- ☐ Use of a cane or a stick almost always
- ☐ Use of one crutch almost always
- ☐ Use of two crutches or a walker
- ☐ Unable to move across the room

7. I am able to walk _____ without a break:

- ☐ Over one mile/Unlimited
- ☐ 6 blocks or roughly 30 minutes
- ☐ 2-3 blocks or roughly 10-15 minutes
- ☐ Indoor walking only
- ☐ Bed and chair only

HIP FOLLOW-UP

— QUESTIONNAIRE

CLINICAL FUNCTION SCORE (CONT'D)

8. Which of the following describes how you take stairs?

- ☐ Normally foot-over-foot without NEEDING the railing
- ☐ Normally using the railing
- ☐ Lead with non-painful hip one step at a time
- ☐ Cannot take the stairs

10. Under what circumstances can you sit comfortably?

- ☐ Any chair/1+ hour
- ☐ High chair/30 minutes
- ☐ Unable to sit comfortably

12. List any unrelated orthopedic issues that could effect your hip function score.

(i.e. bad back, arthritis in other hip, non-hip pain, etc.)

☐ Yes; please list:

☐ No

9. I am able to put socks/shoes on....

- ☐ With ease
- ☐ With difficulty
- ☐ Unable to put socks/shoes on without help

11. Are you able to get in and out of a vehicle without help?

- ☐ Yes
- ☐ No

13. How is your hip joint now compared to before surgery?

- ☐ Better than my normal, healthy, pre-arthritic/damaged hip
- ☐ Feels just like my normal, healthy, pre-arthritic/damaged hip
- ☐ Much better than before surgery, with minor aches and pains
- ☐ Somewhat better than before surgery
- ☐ About the same
- ☐ Worse than before surgery

ACTIVITY SCORE

1. Choose your current level of activity:

1	Wholly inactive; dependent on others, and cannot leave residence
2	Mostly inactive, or restricted to minimum activities of daily living
3	Sometimes participates in mild activities (ex. walking, limited housework or shopping)
4	Regularly participates in mild activities
5	Sometimes participates in moderate activities (ex. swimming, unlimited housework or shopping)
6	Regularly participates in moderate activities
7	Regularly participates in active events, such as bicycling
8	Regularly participates in very active events, such as bowling or golf
9	Sometimes participates in impact sports (ex. jogging, tennis, skiing, ballet, heavy labor, backpacking)
10	Regularly participates in impact sports

HIP FOLLOW-UP

— QUESTIONNAIRE

ACTIVITY SCORE (CONT'D)

2. Please list any activities that you participate in regularly.

3. Please list any vigorous activities that you occasionally participate in.

4. My activity is now _____ compared to before surgery.

☐

Higher

☐

Similar

☐

Lower

FORGOTTEN JOINT SCORE

Are you aware of your artificial joint...?

Choose one grade/number for each question:

1. never | 2. almost never | 3. seldom | 4. sometimes | 5. mostly

☐

1. ...in bed/at night?

☐

7. ...when walking on uneven ground?

☐

2. ...when sitting >1 hour?

☐

8. ...when standing from a low-seated position?

☐

3. ...when walking >15 min?

☐

9. ...when standing for long periods of time?

☐

4. ...when taking a bath/shower?

☐

10. ...when doing housework/gardening?

☐

5. ...when traveling in a car?

☐

11. ...when taking a walk/hike?

☐

6. ...when climbing stairs?

☐

12. ...when doing your favorite sport?

CONCLUSIONS

1. Are you happy with your decision to have this surgery?

☐

Yes

☐

No

2. Do you have any additional comments?

THANK YOU!

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Physical Therapy Request

R_x

Patient - please fill your name, DOB, and evaluation date before your appointment.

FOR (NAME) _____ DOB: _____

ADDRESS _____ DATE _____

Please evaluate both hips in the above patient for range of motion and provide a report on my standardized form included.

AND

Please FAX to **803-933-6775** and give the patient a copy.

A note from Dr. Gross:

"Dear Physical Therapist,

The person presenting this form has had a hip surface replacement performed by Dr. Thomas P. Gross _____ weeks/years ago. We are asking that you objectively evaluate his/her hip and send me a report. If the patient is less than one year postop, the hip cannot be pushed into extreme flexion, adduction and internal rotation. (See form). Please record the range of motion that can be achieved by gentle examination in this case. If the patient is approximately six weeks postop, please review and assist them with my Phase II Hip Exercise Program. The patient has been instructed to bring this with him/her in this situation."

Thomas P. Gross, MD

Digitally signed
Thomas P.
Gross MD
Date: 2025.06.17
09:45:35 -04'00'

HIP FOLLOW-UP

— PHYSICAL EXAM

MIDLANDS
orthopaedics
& NEUROSURGERY

PATIENT - COMPLETE THIS SECTION

- Patient name: _____
- Date of Surgery: ☐ Right hip: _____ | ☐ Left hip: _____
- Type of Surgery: ☐ Right hip: _____ | ☐ Left hip: _____
- Postoperative Interval from Surgery:
(for each side, choose one of the following: **N/A, 6 weeks, 1 year, 2 year, >2 year**)
☐ Right hip: _____ | ☐ Left hip: _____

SECTION TO BE COMPLETED BY 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:

MEASUREMENT	Right	Left
a. Flexion Contracture*	___	___
b. Flexion to**	___	___
c. Abduction @ 45° of flexion to	___	___
d. Adduction @ 45° of flexion to	___	___
e. External Rotation @ 45° of flexion to	___	___
f. Internal Rotation @ 45° of flexion to	___	___
g. IR with knee flexed to 90° ***	___	___

* 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 | 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 | Where? _____

10. Condition of incision: _____

Physical Therapist Signature: _____

Date: _____

PT Print Name: _____

Address: _____

HIP FOLLOW-UP

— X-RAY ORDER

MIDLANDS
orthopaedics
& NEUROSURGERY

***Patient - Please fill your NAME and DATE OF BIRTH before visiting the office.**

R_x

FOR (NAME) _____

DOB: _____

ADDRESS _____

DATE _____

POSTOP PATIENTS - Please choose/circle ONE section (either 1, 2, or 3) to ensure the appropriate x-rays are obtained from the patient's radiology facility.

1. LEFT
 - i. Presence of left artificial hip joint - **Z96.642**
2. RIGHT
 - i. Presence of right artificial hip joint - **Z96.641**
3. BILATERAL
 - i. Presence of artificial hip joint, bilateral - **Z96.643**

Views (please obtain each of the following)

1. AP Pelvis Standing (Please label as "STANDING")
2. AP Pelvis Supine (Please label as "SUPINE")

Please send these x-ray images to us via Nuance PowerShare. **Our facility lookup information is:**
Midlands Orthopaedics & Neurosurgery, 1910 Blanding Street, Columbia, SC 29201

If you are not in the PowerShare network, please mail a CD with digital .DICOM copies of these images to us at:

Midlands Orthopaedics & Neurosurgery
ATTN: Gross MD Hip Follow-Up
1910 Blanding Street Columbia, SC 29201

Digitally signed
by Thomas P.
Gross MD
Date: 2025.06.17
09:45:35 -04'00'

Thomas P.
Gross MD

THANK YOU!

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