

# Hip Follow-Up

1-Year Interval — Remote Evaluation

Your 1-year follow-up marks an important milestone in your recovery. Dr. Gross will review your results and send you a written response. Please complete all three components below. Remote follow-up is available for out-of-state patients at no charge.

## STEP 1

### Complete Your Questionnaire

Fill out the Hip Follow-Up Questionnaire (pages 2–4). Complete one form per hip if both were operated on.

*Included in this packet*  
• Or submit online at [grossortho.com](http://grossortho.com)

## STEP 2

### Complete Your PT Evaluation

Bring the Physical Therapy Request form (page 5) to any licensed PT. Ask your PT to fax results to (803) 933-6775 and give you a copy.

*PT form included • FAX: (803) 933-6775*

## STEP 3

### Get Your X-Ray

Obtain AP Pelvis Standing and AP Pelvis Supine x-rays at any local hospital or radiology facility. Use the X-Ray Order form on the last page.

*Send via Nuance PowerShare OR  
mail a DICOM CD*

## How to Return Your Questionnaire

### ONLINE (Fastest)

Complete the questionnaire at the secure link included in your email. Results go directly to Dr. Gross.

### EMAIL

Print, scan or photograph the form and email to:  
[grosspatientfollowup@midorthoneuro.com](mailto:grosspatientfollowup@midorthoneuro.com)

### MAIL

Print and mail to:  
Midlands Orthopaedics & Neurosurgery  
ATTN: Gross Follow-Up  
1910 Blanding St, Columbia SC 29201

### QUESTIONS? Contact our follow-up team:

*\*If you are having significant issues or prefer to be seen in person, call (803) 256-4107. Routine office charges apply.*

Phone: (803) 933-6127

Email: [grosspatientfollowup@midorthoneuro.com](mailto:grosspatientfollowup@midorthoneuro.com)

Office: (803) 256-4107

# Hip Follow-Up Questionnaire

Complete one form per hip. If both hips were operated on, please fill out a separate form for each side.

## PERSONAL INFORMATION

Full Name: \_\_\_\_\_ Date of Birth (MM/DD/YYYY): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

## ABOUT THIS FOLLOW-UP

- This questionnaire is for my:  LEFT hip  RIGHT hip  BOTH hips
- I have had problems with my:  LEFT hip  RIGHT hip  BOTH hips
- Dr. Gross operated on my:  LEFT hip  RIGHT hip  BOTH hips
- Dr. Gross performed the following procedure(s):  Total Hip Replacement  Hip Resurfacing  Revision Hip Surgery
- Has another surgeon operated on this hip?  Yes  No
- Where was this form completed?  At home  In clinic  Online  By phone

## COMPLICATIONS

1. List any complications you experienced after surgery (check all that apply):

- |                                                              |                                                |
|--------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> None                                | <input type="checkbox"/> Fracture              |
| <input type="checkbox"/> Wound Infection                     | <input type="checkbox"/> Loose Implant         |
| <input type="checkbox"/> Deep Venous Thrombosis (blood clot) | <input type="checkbox"/> Pulmonary Embolism    |
| <input type="checkbox"/> Dislocation                         | <input type="checkbox"/> Partial Sciatic Palsy |

Other: \_\_\_\_\_

2. Did any complication require further surgery?  Yes — please explain: \_\_\_\_\_  
 No

## CLINICAL FUNCTION SCORE

1. My overall pain level:  None/insignificant  Regularly slight  Mild  Moderate  Severe  Disabled

2. Pain location (check all that apply):  No pain  Groin  Buttock  Front of thigh  Side of thigh  Near scar

3. Circle your REGULAR pain level:



4. Circle your HIGHEST pain level:



5. Limp severity:  None  Slight  Mild  Moderate  Severe  Disabled

## Hip Follow-Up Questionnaire (continued)

### CLINICAL FUNCTION SCORE (CONTINUED)

#### 6. Use of walking support:

- |                                                   |                                                                          |
|---------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> None required            | <input type="checkbox"/> Cane/stick for long walks or high activity only |
| <input type="checkbox"/> Cane/stick almost always | <input type="checkbox"/> One crutch almost always                        |
| <input type="checkbox"/> Two crutches or a walker | <input type="checkbox"/> Unable to move across the room                  |

#### 7. Walking distance without a break:

- |                                                      |                                                 |
|------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Over 1 mile / unlimited     | <input type="checkbox"/> ~6 blocks / 30 minutes |
| <input type="checkbox"/> ~2–3 blocks / 10–15 minutes | <input type="checkbox"/> Indoor walking only    |
| <input type="checkbox"/> Bed and chair only          |                                                 |

#### 8. Taking stairs:

- |                                                                           |                                                      |
|---------------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Normally, foot-over-foot, no railing needed      | <input type="checkbox"/> Normally, using the railing |
| <input type="checkbox"/> One step at a time, leading with non-painful hip | <input type="checkbox"/> Cannot take the stairs      |

#### 9. Putting on socks/shoes:

- |                                              |                                          |
|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> With ease           | <input type="checkbox"/> With difficulty |
| <input type="checkbox"/> Unable without help |                                          |

#### 10. Sitting comfortably:

- |                                                    |                                                  |
|----------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Any chair / 1+ hour       | <input type="checkbox"/> High chair / 30 minutes |
| <input type="checkbox"/> Unable to sit comfortably |                                                  |

#### 11. Able to get in/out of a vehicle without help? Yes No

#### 12. Any unrelated orthopedic issues affecting your score?

(e.g., back pain, arthritis in other hip, knee issues)

- Yes — please describe: \_\_\_\_\_
- No

#### 13. How does your hip compare to before surgery?

- |                                                                        |                                                                        |
|------------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Better than my pre-arthritis/healthy hip      | <input type="checkbox"/> Feels just like my healthy, pre-arthritis hip |
| <input type="checkbox"/> Much better than before surgery (minor aches) | <input type="checkbox"/> Somewhat better than before surgery           |
| <input type="checkbox"/> About the same                                | <input type="checkbox"/> Worse than before surgery                     |

### ACTIVITY SCORE

#### 1. Choose your current activity level (circle one number):

- 1 — Wholly inactive; dependent on others
- 2 — Mostly inactive; minimum daily activities only
- 3 — Sometimes participates in mild activities (walking, limited shopping)
- 4 — Regularly participates in mild activities
- 5 — Sometimes participates in moderate activities (swimming, unlimited shopping)
- 6 — Regularly participates in moderate activities
- 7 — Regularly participates in active events (cycling)
- 8 — Regularly participates in very active events (bowling, golf)
- 9 — Sometimes participates in impact sports (jogging, tennis, skiing)
- 10 — Regularly participates in impact sports

#### 2. Regular activities: \_\_\_\_\_

#### 3. Occasional vigorous activities: \_\_\_\_\_

#### 4. Compared to before surgery, my activity is now: Higher Similar Lower

## Hip Follow-Up Questionnaire (continued)

### FORGOTTEN JOINT SCORE

How often are you aware of your artificial joint during the following? Rate each: 1=Never 2=Almost never 3=Seldom 4=Sometimes 5=Mostly

1. In bed / at night

1	2	3	4	5
---	---	---	---	---

2. Sitting on a chair for >1 hour

1	2	3	4	5
---	---	---	---	---

3. Walking for >15 minutes

1	2	3	4	5
---	---	---	---	---

4. When taking a bath/shower

1	2	3	4	5
---	---	---	---	---

5. When traveling in a car

1	2	3	4	5
---	---	---	---	---

6. When climbing stairs

1	2	3	4	5
---	---	---	---	---

7. When walking on uneven ground

1	2	3	4	5
---	---	---	---	---

8. Standing from a low-seated position

1	2	3	4	5
---	---	---	---	---

9. When standing for long periods

1	2	3	4	5
---	---	---	---	---

10. Doing housework or gardening

1	2	3	4	5
---	---	---	---	---

11. When taking a walk/hike

1	2	3	4	5
---	---	---	---	---

12. When doing your favorite sport

1	2	3	4	5
---	---	---	---	---

### CONCLUSIONS

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

Yes

No

**2. Are you happy with the outcomes of your surgery?**

Yes

No

**3. Do you have any additional comments?**

# Physical Therapy Request

**ORDERING PHYSICIAN**

Thomas P. Gross, MD

**Rx**Digitally signed: Thomas P. Gross, MD  
Date: 2026.JUN.30**PATIENT INFORMATION (Please fill in before your PT appointment)**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Eval Date: \_\_\_\_\_

**Instructions to Physical Therapist:**

- Please evaluate both hips for range of motion using the standardized form below.
- FAX results to (803) 933-6775 and give the patient a copy.
- If patient is < 1 year postop: do NOT push into extreme flexion, adduction, or internal rotation.
- If patient is ~6 weeks postop: please review the Phase II Hip Exercise Program with the patient.

**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. 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. Please record the range of motion that can be achieved by gentle examination. If the patient is approximately six weeks postop, please review and assist them with my Phase II Hip Exercise Program."*

# Physical Exam Form

## PATIENT — COMPLETE THIS SECTION

**Patient Name:** \_\_\_\_\_

**Date of Surgery:**     Right hip: \_\_\_\_\_                       Left hip: \_\_\_\_\_

**Type of Surgery:**     Right hip: \_\_\_\_\_                       Left hip: \_\_\_\_\_

**Postoperative Interval:** (choose: 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:

	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 leg lies flat on exam table

\*\* Do not push past 100° before 1 year

\*\*\* Do not perform until 1 year post surgery

**3. Gait:**     Normal     Antalgic     Trendelenburg     Short Leg

**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 INFORMATION

**Physical Therapist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PT Print Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

# Hip X-Ray Order

Bring or present this form to any local hospital or freestanding radiology facility.

**ORDERING PHYSICIAN**
**Thomas P. Gross, MD**

Midlands Orthopaedics &amp; Neurosurgery

# Rx

Digitally signed: Thomas P. Gross, MD

Date: 2026.JUN.30

**PATIENT INFORMATION (Please complete before visiting the radiology facility)**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

**STEP 1 - Select Your Hip Side**
 **LEFT HIP**

Presence of left artificial hip joint

*ICD-10: Z96.642*
 **RIGHT HIP**

Presence of right artificial hip joint

*ICD-10: Z96.641*
 **BILATERAL (Both Hips)**

Presence of artificial hip joints, bilateral

*ICD-10: Z96.643*
**STEP 2 - X-Ray Views Required (Obtain BOTH)**
**View 1: AP Pelvis STANDING**

Label image as "STANDING" -Weight-bearing, upright position

**View 2: AP Pelvis SUPINE**

Label image as "SUPINE" - Lying down, non-weight-bearing

**STEP 3 - Send X-Ray Images to Dr. Gross**
**PREFERRED: Nuance PowerShare (electronic)**

Ask the radiology facility to send images via Nuance PowerShare.

Search: Midlands Orthopaedics &amp; Neurosurgery, 1910 Blanding St, Columbia SC 29201

**ALTERNATIVE: Mail a CD**

Request a CD with digital DICOM image files and mail to:

Midlands Orthopaedics &amp; Neurosurgery, ATTN: Gross MD Hip Follow-Up

1910 Blanding Street, Columbia, SC 29201