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Orthopaedic Surgery & Sports Medicine
INITIAL EVALUATION FORM

Name: _____ Age: _____ Date: _____

Occupation / job? _____ Did another doctor send you to us? Yes / No
Name of provider: _____

Involved Site? Shoulder Hip Knee Other: _____

Which side(s)? Right / Left / Both Dominant hand/arm? Right / Left

Problem(s) (Please check all that apply): Pain Weakness Instability/dislocation Stiffness Swelling Other: _____

Buckling Locking Grinding Clicking Catching

Difficulty with functional activities: Walking Stairs Running Squatting Pivoting/twisting Sitting w/ knee bent

Sitting for long time w/ hip flexed Lifting objects Other: _____

How did you injure yourself? No Specific Injury Sports Related _____ Auto-DOA: _____ Work-DOI: _____

Sports level: None Recreational College Professional

How long have you had symptoms/pain? _____ Days _____ Weeks _____ Months _____ Years

Briefly describe your injury: _____

Location of your pain: _____

Given diagnosis (if known): _____

Non-surgical treatments (ie; injection, physical therapy, etc) _____

Previous surgery for this injury: _____

Severity of Pain: None Mild Moderate Severe

Pain Worse With: _____

Pain Better With: _____

Do you have pain at night? Yes No Does it wake you up at night? Yes No

Are you currently working? Yes No Retired Full Duty Limited Duty

Do you have any imaging studies? X-rays MRI CT Scan

Please list ALL Allergies: _____

Do you have any of the following medical conditions: (please circle): Heart problems Ulcers Diabetes Cancer Seizures

Liver Problems/Hepatitis Kidney Disease Blood Clots Asthma

Sleep Apnea Stroke Other: _____

Please list all medications including over the counter medications and herbal supplements: _____
