INITIAL EVALUATION FORM

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Shoulder, Knee, Elbow Surgery / Sports Medicine
The Steadman Clinic

NAME: _____

Age: _____ **Today's Date:**_____

Date of Birth: _____

Height: _____ **Weight:** _____

Who referred you to us?
If yes, please give name / address of the person/physician:

_____

Occupation? _____

Where is your problem? (please circle)

Shoulder Knee Elbow

Neck Back Other

Which side(s)? Right / Left / Both

Dominant Arm? Right / Left

Problem(s) (please check all that apply):

- ☐ Pain
- ☐ Weakness
- ☐ Instability / giving way / dislocation?
- ☐ Stiffness?
- ☐ Swelling?
- ☐ Other _____

How did you injure yourself?

- ☐ No injury
- ☐ Sports (which sport?)_____
- ☐ Motor vehicle accident
- ☐ Work / job –

Is there a workers comp claim? Yes / No

Sports level: none / recreational / college / professional

Date of injury?_____

How long have you had symptoms?
_____ Days _____ Mos. _____ Yrs.

Please briefly describe the injury:

_____

_____

Diagnosis (if you know or have been told)?

_____

Previous treatments (other than surgery)?
(medications, physical therapy, injections, bracing)

_____

_____

Previous surgery for this problem (include dates)

_____

_____

How severe is the pain? ***(0 = none, 10 = severe pain)***

At rest? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Do you have pain at night? Yes / No

Does it waken you from sleep? Yes / No

Are you currently working? Yes / No / Retired

☐ Normal job? ☐ Limited duty?

What makes your problem better?

_____

What makes your problem worse?

_____

Please describe your current limitations?

_____

Have you had any previous imaging studies?

X-rays	No / Yes	date:_____
MRI	No / Yes	date:_____
CAT scan	No / Yes	date:_____

PAST MEDICAL HISTORY:

- ☐ High blood pressure _____
- ☐ Heart problems _____
- ☐ History of Heart attack_____
- ☐ Stroke _____
- ☐ Seizures _____
- ☐ Asthma _____
- ☐ Gastritis _____
- ☐ Kidney disease _____
- ☐ History of Cancer _____
- ☐ Osteoporosis _____
- ☐ History of blood clot/embolus_____
- ☐ Blood clotting disorder_____
- ☐ Diabetes _____
- ☐ History of skin infections_____MRSA_____
- ☐ Other _____

_____

MEDICATIONS: (please list all medications you are currently taking)

_____

_____

_____

ALLERGIES:

Are you allergic to Latex ❑ Yes ❑ No

Allergies to Medications? ❑ None _____

SOCIAL HISTORY:

Marital Status: _____

Residency: _____

Alcohol use: ❑ Daily ❑ Socially ❑ Never Tobacco use: ❑ Yes ❑ No

FAMILY HISTORY: (please list diseases that run in your family)

_____

Family history of blood clots _____ Bleeding disorders _____

REVIEW OF SYSTEMS:

1. CONSTITUTIONAL ❑ None ❑ Recent weight change ❑ Chills ❑ Fever ❑ Weakness/Fatigue
   GENERAL ❑ _____

2. EYES ❑ None ❑ Vision change ❑ Glasses/Contacts ❑ Cataracts ❑ Glaucoma
   ❑ Other _____

3. EARS, NOSE, THROAT ❑ None ❑ Loss of hearing ❑ Ear ache or infection ❑ Ringing in ear ❑ Hoarseness
   ❑ Other _____

4. CARDIOVASCULAR ❑ None ❑ Chest Pain ❑ Swelling in legs ❑ Shortness in breath ❑ Palpitations
   ❑ Other _____

5. RESPIRATORY ❑ None ❑ Shortness of breath ❑ Wheezing/Asthma ❑ Frequent Cough
   ❑ Other _____

6. GASTROINTESTINAL ❑ None ❑ Heartburn ❑ Acid Reflex ❑ Nausea or vomiting ❑ Abdominal Pain
   ❑ Other _____

7. MUSCULOSKELETAL ❑ None ❑ Arthritis / joint stiffness ❑ Muscle aches ❑ Swelling of joints
   ❑ Other _____

8. SKIN ❑ None ❑ Rash ❑ Ulcers ❑ Abnormal scars ❑ Sores
   ❑ Other _____

9. NEUROLOGICAL ❑ None ❑ Headaches ❑ Fainting/blackouts ❑ Numbness, tingling, loss of sensation in any part of body ❑ Dizziness
   ❑ Other _____

10. PSYCHIATRIC ❑ None ❑ Depression ❑ Nervousness ❑ Anxiety ❑ Mood Swing
    ❑ Other _____

11. ENDOCRINE ❑ None ❑ Excessive thirst or hunger ❑ Hot/cold intolerance ❑ Hot Flashes
    ❑ Other _____

12. HEMATOLOGICAL ❑ None ❑ Easy Bruising ❑ Easy Bleeding ❑ Anemia
    ❑ Other _____

Signature: _____ Date: _____

Name: _____