



INITIAL EVALUATION FORM

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Shoulder, Knee, Elbow Surgery / Sports Medicine
Steadman Clinic

NAME: _____

Age? _____ Today's Date? _____

Date of Birth? _____

Occupation / job? _____

Did another doctor send you to us? Yes / No

If yes, please give name / address of that physician:

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 – just started hurting
- 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 imaging studies?

X-rays No / Yes date: _____

MRI No / Yes date: _____

CAT scan No / Yes date: _____

Are you interested in surgery to correct your problem?

Please circle one: No / Yes / Unsure

Allergies to medication(s)? _____

Do any diseases run in your family? _____

Medical History: (please circle)

Do / did you have any heart problems? No / Yes

Do / did you have ulcers / gastritis? No / Yes

Do / did you have diabetes? No / Yes

Do / did you have liver problems, hepatitis? No / Yes

Do / did you have kidney disease? No / Yes

Do / did you have blood clots? No / Yes

Do / did you have cancer? No / Yes

Do / did you smoke? No / Yes

Other? (please use back of sheet as necessary)

REVIEW OF SYSTEMS

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

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:_____