



INITIAL EVALUATION FORM
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 Shoulder, Knee, Elbow Surgery / Sports Medicine
 Steadman Hawkins 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) | |