THE STEADMAN CLINIC REGISTRATION

PATIENT INFORMATION Today's Date _____

Patient Name _____
Last First (Legal) Initial Nickname

Date of Birth _____ Age _____ SS# _____ Sex ☐ M ☐ F

Race _____ Ethnicity _____ Language _____

Cell Phone _____ Work Phone _____ Home Phone _____

E-mail Address _____ Marital Status _____

Mailing Address _____ City _____

State _____ Zip Code _____

Physical Address _____ City _____

State _____ Zip Code _____

Occupation _____ Retired? ☐ Y ☐ N

Emergency Contact _____

Relationship _____ Phone _____

Primary Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

WERE YOU REFERRED BY A MEDICAL PROFESSIONAL?

Referral Name: _____ City/State _____

How did you hear about us? Medical Professional ☐ Family / Friend ☐ Internet/Website ☐

Other ☐ _____

PRIMARY INSURANCE : _____

POLICY HOLDER NAME _____ DOB _____ Relationship_____

SECONDARY INSURANCE: _____

POLICY HOLDER NAME _____ DOB _____ Relationship_____

OTHER: _____

INITIAL EVALUATION FORM

Peter J. Millett, M.D., M.Sc.
Shoulder, Knee, Elbow Surgery / Sports Medicine

Name: _____
Age: _____ Today's Date: _____
Date of Birth: _____
Height: _____ Weight: _____
Who referred you to us?
_____
_____
Current Occupation:
_____

Where is your problem? (please circle)
Shoulder ☐ Knee ☐ Elbow ☐
Neck ☐ Back ☐ Other ☐
Side: Left / Right / Both
Dominant Arm: Left / Right
Problem: (check all that apply)

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

How did you injure yourself?

- ☐ No injury
- ☐ Sports (specify) _____
- ☐ Motor Vehicle Accident
- ☐ Work/Job

Workers Comp claim: Yes ☐ / No ☐
Sports Level: None / Recreational / College / Pro
Date of Injury: _____
How long have you had symptoms?
_____
Briefly describe injury: _____
_____
Diagnosis (if known): _____
_____
Previous non-surgical treatments: (meds, physical therapy, injections, bracing)
_____
_____

Previous surgery for this problem (with dates)
_____
_____

How severe is the pain? (0=none, 10=severe)
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
Pain at night: Yes / No
Pain wakes you from sleep: Yes / No
Are you currently working? Yes / No / Retired
Job duties level: Normal / Limited
Interested in surgery: Yes / No / Unsure

What makes your problem better?
_____
_____
What makes your problem worse?
_____
_____
Describe your current limitations:
_____
_____
Previous imaging studies for this problem:
X-rays Yes / No Date:_____
MRI Yes / No Date:_____
CT Yes / No Date:_____

MEDICAL HISTORY:
☐ High blood pressure _____
☐ Heart problems _____
☐ Heart attack _____
☐ Stroke _____ ☐ Seizures_____
☐ Asthma _____ ☐ Gastritis _____
☐ Kidney disease _____ ☐ Cancer _____
☐ Osteoporosis _____
☐ History of blood clot/embolus _____
☐ Blood clotting disorder _____
☐ Diabetes _____
☐ History of skin infections _____
☐ MRSA _____

MEDICATIONS: (please all current medications)

_____

_____

_____

ALLERGIES: Allergic to latex: Yes / No
Allergies to medications: None / _____

SOCIAL HISTORY: Marital Status: _____ Residency: _____
Alcohol use: Daily / Socially / Never Tobacco Use: Yes / No / Former

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

_____

_____

Family history of blood clots: Yes / No _____ Family history of bleeding disorders: Yes / No _____

REVIEW OF SYSTEMS: (circle all that apply)
1. CONSTITUTIONAL/GENERAL: None / Recent weight change / Chills / Fever / Weakness or fatigue

_____

2. EYES: None / Vision change / Glasses or contacts / Cataracts / Glaucoma / Other

_____

3. EARS, NOSE, THROAT: None / Hearing loss / Earache or infection / Ringing in ear / Hoarseness / Other

_____

4. CARDIOVASCULAR: None / Chest Pain / Swelling in legs / Shortness of breath / Palpitations / Other

_____

5. RESPIRATORY: None / Shortness of breath / Wheezing or asthma / Frequent cough / Other

_____

6. GASTROINTESTINAL: None / Heartburn / Acid reflux / Nausea or vomiting / Abdominal pain / Other

_____

7. MUSCULOSKELETAL: None / Arthritis or joint stiffness / Muscle aches / Swelling of joints / Other

_____

8. SKIN: None / Rash / Ulcers / Abdominal Scars / Sores / Other

_____

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

_____

10. PSYCHIATRIC: None / Depression / Nervousness / Anxiety / Mood swings / Other

_____

11. ENDOCRINE: None / Excessive thirst or hunger / Heat or cold intolerance / Hot flashes / Other

_____

12. HEMATOLOGICAL: None / Easy bruising / Easy bleeding / Anemia / Other

_____

Signature: _____ Date: _____