



**INITIAL EVALUATION FORM**  
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 Shoulder, Knee, Elbow Surgery / Sports Medicine  
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**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)