**INITIAL EVALUATION FORM**  
**Koman Orthopedics and Sports Medicine**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Age:</td>
<td>____________ Today's Date: ________________</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>________________________________</td>
</tr>
<tr>
<td>Height:</td>
<td>____________ Weight: ____________</td>
</tr>
<tr>
<td>Who referred you to us?</td>
<td>If yes, please give name/address of person/physician:</td>
</tr>
</tbody>
</table>

**Occupation?** ____________________________

**Where is your problem?**  (please circle)
- Shoulder
- Elbow
- Wrist/Hand
- Knee
- Hip
- Ankle/foot
- Back
- Neck
- 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 - Workers claim? Yes / No

**Date of injury?** ____________________________

**Sports level:** none/recreational/college/professional

**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 night pain?** 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 Yes / No date: ______________
- MRI Yes / No date: ______________
- CT scan Yes / No date: ______________
- Other Yes / No date: ______________
INITIAL EVALUATION FORM
Koman Orthopedics and Sports Medicine

PAST MEDICAL HISTORY:

☐ High blood pressure
☐ Heart problems
☐ History of heart attack
☐ Stroke
☐ Kidney disease
☐ History of Cancer
☐ Osteoporosis
☐ Blood clot/embolus
☐ Blood clotting disorder
☐ Diabetes
☐ Skin infections
☐ MRSA
☐ Other

ALLERGIES:

☐ NO KNOWN DRUG ALLERGIES
☐ Penicillin
☐ Sulfa
☐ Other

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

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

☐ Blood clots
☐ Bleeding disorders
☐ Other

SOCIAL HISTORY:

Marital status:

Alcohol use: ☐ Daily ☐ Socially ☐ Never

Tobacco use: ☐ Yes - Packs per day _____ ☐ No

PAST SURGICAL HISTORY: (include dates)

REVIEW OF SYSTEMS:

-GENERAL ☐ None ☐ Recent weight change ☐ Fever ☐ Weakness/fatigue
☐ Other

-EYES ☐ None ☐ Vision change ☐ Glasses/Contacts ☐ Glaucoma ☐ Cataracts
☐ Other

-EARS, NOSE, THROAT ☐ None ☐ Loss of hearing ☐ Ear ache/infection ☐ Ringing in ear ☐ Hoarseness
☐ Other

-CARDIOVASCULAR ☐ None ☐ Chest pain ☐ Swelling in legs ☐ Shortness in breath ☐ Palpitations
☐ Other

-RESPIRATORY ☐ None ☐ Shortness of breath ☐ Wheezing/Asthma ☐ Frequent Cough
☐ Other

-GASTROINTESTINAL ☐ None ☐ Heartburn ☐ Acid Reflux ☐ Nausea or Vomiting ☐ Abdominal pain
☐ Other

-MUSCULOSKELETAL ☐ None ☐ Arthritis/joint stiffness ☐ Muscle Aches ☐ Swelling of Joints
☐ Other

-SKIN ☐ None ☐ Rash ☐ Ulcers ☐ Abdominal Scars ☐ Sores
☐ Other

-NEUROLOGICAL ☐ None ☐ Headaches ☐ Fainting/Blackouts ☐ Numbness, tingling, loss of sensation ☐ Dizziness
☐ Other

-PSYCHIATRIC ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety ☐ Mood Swing
☐ Other

-ENDOCRINE ☐ None ☐ Excessive thirst or hunger ☐ Hot/cold intolerance ☐ Hot Flashes
☐ Other

-HEMATOLOGICAL ☐ None ☐ Easy bruising ☐ Easy bleeding ☐ Anemia
☐ Other

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

Signature: ____________________________ Date: ________________