INITIAL EVALUATION FORM
Koman Orthopedics and Sports Medicine

NAME: _____

Age: _____ **Today's Date:** _____

Date of Birth: _____

Height: _____ **Weight:** _____

Who referred you to us?
If yes, please give name/address of person/physician:

_____

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: _____

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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 _____

SOCIAL HISTORY:

Marital status: _____

Alcohol use: ☐ Daily ☐Socially ☐ Never

Tobacco use: ☐ Yes - Packs per day _____

☐ No

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

_____

_____

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

☐ Blood clots_____

☐Bleeding disorders _____

☐Other _____

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 _____

Signature: _____ **Date: _____**