Patient ID will go here.

Welcome!

Initial Patient Evaluation Form

Johns Hopkins Shoulder & Sports Medicine

PATIENT'S INFORMATION

Patient Name ______________________

Address ______________ City ______________ State ______ ZIP ______

Email ______________ Ok for office to contact you by email? ☐ Yes ☐ No

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Age ______ Date of Birth ______________ Occupation/Employer ______________

How did you hear about our practice? ☐ Physician ☐ Family ☐ Friend ☐ Newspaper ☐ Flyer/Mailing ☐ Seminar ☐ Emergency room ☐ Physical Therapist/Athletic Trainer ☐ Urgent care (Patient First) ☐ Hopkins website ☐ Online search (Google) ☐ Other ______________

Name of Referral Source ______________ Address ______________

Name of Primary Care Physician ______________ Address ______________

ORTHOPAEDIC HISTORY

Briefly describe your current problem ______________________

____

Are you?:
☐ Right handed ☐ Left handed ☐ Both

Where is your current problem? ☐ Right ☐ Left
☐ Shoulder ☐ Elbow ☐ Neck/Back
☐ Knee ☐ Ankle ☐ Other ______________

Localize your pain: ☐ Inside ☐ Outside
☐ In front of ☐ In the back of
☐ Behind ☐ On the side of
☐ On top ☐ On bottom

When did your problem begin? ______________

How long have you had symptoms?
☐ Days ☐ Weeks ☐ Months ☐ Years

Did you injure yourself? ☐ No ☐ Yes *If yes, how:*
☐ Sports (which sport?) ______________
☐ Car accident ☐ Fall ☐ Work/job
☐ Other injury ______________

Is there a worker's comp claim? ☐ No ☐ Yes

Are you currently working? ☐ No ☐ Yes

Do you have pain? ☐ No ☐ Yes

Rate your pain from: 0 (none) to 10 (severe) ______

Is your pain?: ☐ worsening ☐ improving
☐ no change?

Describe your pain: ☐ Ache ☐ Deep
☐ Throbbing ☐ Stabbing ☐ Shooting
☐ Sharp ☐ Burning ☐ Tingling

Does your pain radiate/extend to other parts of your body? ☐ No ☐ Yes *If yes where:*

____

When do you have pain? ☐ At rest
☐ With movement ☐ With activities
☐ With sports ☐ Occasionally
☐ Morning ☐ Day ☐ Night

How long does your pain last? ☐ Seconds
☐ Minutes ☐ Hours ☐ Constant

Does your pain prevent you from sleeping?
☐ No ☐ Yes

Does your pain wake you up from sleep?
☐ No ☐ Yes

ORTHOPAEDIC HISTORY continued

What makes your problem better?____________________ **Worse?** ____________________

Do you have associated: ☐ clicking ☐ catching ☐ locking up ☐ buckling ☐ stiffness ☐ swelling ☐ numbness ☐ weakness

Do you have any sense of: ☐ instability ☐ giving way **episodes of:** ☐ subluxation ☐ dislocation

How would you rate your injured joint today as a % of normal (0-100%)

with 100% being completely normal?__________%

Describe your current limitations (with work, leisure, activities, etc):______________________________

____

Have you had any previous treatments? ☐ No ☐ Yes

Have you taken medication for current problem? ☐ No ☐ Yes *If yes, list with dosage and duration*

Medication	Dosage	Duration	Outcome
__________	______	______	☐ Helped a little ☐ A lot ☐ Not at all
__________	______	______	☐ Helped a little ☐ A lot ☐ Not at all
__________	______	______	☐ Helped a little ☐ A lot ☐ Not at all

Injections (cortisone)? ☐ No ☐ Yes How many ______

Outcome: ☐ Helped a little ☐ A lot ☐ Not at all

How long did it last? ____________________

Bracing? ☐ No ☐ Yes

Outcome: ☐ Helped a little ☐ A lot ☐ Not at all

Physical Therapy? ☐ No ☐ Yes

How often ________ For how long__________

Outcome: ☐ Helped a little ☐ A lot ☐ Not at all

For Office Use:

Previous Surgery for this problem? ☐ No ☐ Yes

Year	Type of Surgery	Surgeon	Outcome
______	__________	__________	☐ Better ☐ Worse ☐ Same
______	__________	__________	☐ Better ☐ Worse ☐ Same
______	__________	__________	☐ Better ☐ Worse ☐ Same

PAST MEDICAL HISTORY

Please check boxes that apply to you for illnesses you have or conditions you take medication for.

- ☐ None
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ High Cholesterol
- ☐ Arrhythmia/Irregular Beat
- ☐ Pacemaker
- ☐ Stroke/TIA
- ☐ COPD/Emphysema
- ☐ Cancer (Type)__________
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Stomach Ulcers/Gastritis
- ☐ Acid Reflux Disease
- ☐ Asthma
- ☐ Thyroid Problems
- ☐ Liver Problems
- ☐ Blood Clots or Clots in Lung
- ☐ Bleeding Problems
- ☐ Easy Bruising
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Psoriasis
- ☐ Lupus
- ☐ Depression
- ☐ Anxiety
- ☐ Dementia
- ☐ HIV
- ☐ Hepatitis B/C

PAST MEDICAL HISTORY continued

Please list other illnesses you have or conditions you take medication for.

☐ ______________ ☐ ______________ ☐ ______________
☐ ______________ ☐ ______________ ☐ ______________

Could you be pregnant? ☐ No ☐ Yes

IF YES, DO NOT TAKE X-RAYS; Notify physician and X-ray technician.

SURGICAL HISTORY

List any surgeries you have had and their approximate date—include general and orthopaedic surgeries.

Type of Surgery	Apx. Date	Type of Surgery	Apx. Date

MEDICATIONS

Do you take any blood thinners (i.e., Coumadin, aspirin, Plavix, NSAIDS-Motrin, Alleve, Ibuprofen etc.)?

☐ No ☐ Yes

List all medications, with dosages, that you are taking (prescriptions, over-the-counter, herbal and nutritional supplements.

Medication	Dosage	Medication	Dosage	Medication	Dosage

ALLERGIES

List all allergies, including medications, and the reactions they cause. ☐ ***None***

Allergen			Reaction	Allergen	Reaction
Betadine	☐ No	☐ Yes			
Iodine	☐ No	☐ Yes			
Latex	☐ No	☐ Yes			

FAMILY HISTORY

List medical conditions that run in your family or those which your parent or siblings have (heart disease, diabetes, cancers, rheumatologic conditions, genetic conditions, easy bruising, bleeding or clotting disorders, etc.) ☐ ***None***

Mother ______________

Father ______________

Siblings ______________

SOCIAL HISTORY

Please check boxes that apply to you.

Education: ☐ Grade School ☐ High School ☐ College ☐ Graduate School

Employment Status: ☐ Employed ☐ Student ☐ Unemployed ☐ Work in the home ☐ Retired

Current Sports Participation: ☐ High School ☐ College ☐ Club ☐ Recreational ☐ Professional

Exercise: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Which exercises ____________________

Do you live alone? ☐ No ☐ Yes **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children? ☐ No ☐ Yes – Number______

Smoking History

☐ Never Smoked

☐ Currently Smoke ______ pack(s) per day for _____ years

☐ Smoked in the past, but quit ______ pack(s) per day for _____ years

Do you drink alcohol? ☐ No ☐ Yes

If yes list number of drinks: Daily_______ Weekly_______ Monthly_______ Yearly______

Do you have a history of substance abuse (drug use, etc.) ? ☐ No ☐ Yes

If yes, list substances____________________

REVIEW OF SYSTEMS

Please check boxes that apply to you.

GENERAL
- ☐ Good general health
- ☐ Chills
- ☐ Fevers
- ☐ Night sweats
- ☐ Fatigue
- ☐ Dizziness
- ☐ Loss of appetite
- ☐ Weight loss >10lbs
- ☐ Weight gain >10lbs

SKIN
- ☐ Dryness
- ☐ Excessive sweating
- ☐ Rash

HEAD/NECK
- ☐ Blurry vision
- ☐ Sinusitis
- ☐ Fainting

NECK
- ☐ Difficulty swallowing

RESPIRATORY
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Wheezing

CARDIAC
- ☐ Chest pain
- ☐ Swelling in legs
- ☐ Night cramps
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Skipped heartbeats

GASTROINTESTINAL
- ☐ Reflux/GERD
- ☐ Anorexia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn

GENITOURINARY
- ☐ Hesitancy
- ☐ Incontinence
- ☐ BPH
- ☐ Prostate problems
- ☐ Menstrual irregularities

NEUROLOGICAL
- ☐ Dizziness
- ☐ Headaches
- ☐ Incontinence stool
- ☐ Incontinence urine
- ☐ Loss of balance

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in sleep pattern
- ☐ Depression

ENDOCRINE
- ☐ Frequent urination
- ☐ Appetite changes
- ☐ Cold intolerance

HEMATOLOGY
- ☐ Anemia
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Prolonged bleeding
- ☐ Spontaneous bleeding

SUMMARY
- ☐ All Other Systems Negative

Reviewed by Uma Srikumaran MD Signature ____________________ Date__________