JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL

Patient ID will go here.

Welcome!

Name _____

Date _____

Return Patient Evaluation Form
Johns Hopkins Shoulder & Sports Medicine

Reason for today's visit: ☐ Right ☐ Left _____

Have you had any recent surgery? ☐ No ☐ Yes – *If yes:*

Date _____ Procedure _____

SINCE YOUR LAST VISIT:

How is your pain? ☐ No pain

Rate your pain from 0 (none) to 10 (severe) ___

Is your pain: ☐ worsening ☐ improving ☐ no change

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

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

How is your joint motion? ☐ worsening ☐ improving ☐ no change

Have you had any new injuries? ☐ No ☐ Yes

How would you rate your injured joint today as a percent of normal (0-100%) with 100% being completely normal?_____ %

Have you experienced any of the following: Please check boxes that apply to you.

- ☐ I have been in good general health
- ☐ Problems with your wound (redness/swelling/drainage)
- ☐ Chills
- ☐ Fevers
- ☐ Night sweats
- ☐ Fatigue
- ☐ Numbness
- ☐ Tingling
- ☐ Leg pain
- ☐ Leg swelling
- ☐ Rash
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Fainting
- ☐ Palpitations
- ☐ Problems with your vision
- ☐ Problems with your hearing
- ☐ Problems with your speech
- ☐ Problems with your bladder/urinating
- ☐ Problems with your bowels
- ☐ Constipation
- ☐ Diarrhea
- ☐ Problems with your stomach
- ☐ Reflux/GERD
- ☐ Heartburn

What is your current work status? ☐ Working full time without restriction ☐ Working full time-light duty ☐ Working part time ☐ Working part time-light duty ☐ Just returned to work ☐ Not working at all ☐ On disability

Have you had any diagnostic studies? ☐ X-rays ☐ CT ☐ MRI ☐ Injection ☐ EMG

Have you started any treatments? ☐ No ☐ Yes

Are you taking 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

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

Reviewed by Uma Srikumaran MD Signature _____ Date_____