WESTERN ORTHOPAEDICS
1830 Franklin Street, Suite 450
Denver, Colorado 80218

Initial Patient Evaluation Form

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Orthopaedic Surgeon – Specialist in
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NAME: _____

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

Date of Birth: _____ **Marital Status:** _____

Occupation/Job: _____

Did another Doctor send you to us? Yes / No
If yes, please give name and address of physician:
_____
_____
_____

Where is your problem? (please circle)

Ankle Knee Hip Elbow

Shoulder Back Wrist Other

Which Side? Right / Left / Both
Dominant Arm? Right / Left

Problems (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
Date of Injury? _____

How long have you had Symptoms? _____

Briefly describe your injury:
_____

Diagnosis (if you know or have been told)?
_____

Previous Treatments (medications, Physical Therapy, Injections, bracing, or surgery) _____
_____
_____
_____

Sports Level: None / Recreational / Competitive

Practitioner's Initials and Date: _____

Previous Surgeries (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
Is the pain getting:
Better Worse Same

What makes your problem better? _____
_____
What makes your problem worse? _____
_____

Are you currently working? Yes / No / Retired
☐ Normal Job ☐ Limited Duty
Please describe your current limitations? _____
_____

Have you had any Imaging Studies?
X-rays Yes / No Date: _____
MRI Yes / No Date: _____
Cat Scan Yes / No Date: _____

Allergic to Latex? Yes / No
Allergies to Medications or foods? _____

Please list your medications, the dose and frequency:
_____
_____
_____
_____
_____

Do you take Aspirin? Yes / No
Do any diseases run in your family?_____
_____

Medical History (Please circle)
Do/Did you have high blood pressure? Yes / No
Do/Did you have any heart problems? Yes / No
Do/Did you have ulcers or gastritis? Yes / No
Do/Did you have Diabetes? Yes / No
Do/Did you have liver problems/Hepatitis? Yes / No
Do/Did you have kidney disease? Yes / No
Do/Did you have Cancer? Yes / No
Do/Did you smoke or chew tabacco? Yes / No
Do you have HIV or Hepatitis C? Yes / No
Did you ever have a Blood clot or embolus? Yes / No

CONTINUED ON REVERSE SIDE

Additional Medical Questions:

1. Have you ever had RSD (Reflex Sympathetic Dystrophy)? Yes / No
2. Do you have Sleep Apnea? Yes / No If yes, what do you use: _____
3. Did you ever have a significant joint or bone infection? Yes / No
   If yes, please explain: _____
4. Have you ever been told that your family is predisposed to blood clots? Yes / No

Review of Systems:

1. **Constitutional/ General** ☐ **None** ☐ Recent Weight Change ☐ Chills ☐ Fever ☐ Weakness/Fatigue ☐ Other: _____
2. **Eyes** ☐ **None** ☐ Vision change ☐ Glasses/Contacts ☐ Cataracts ☐ Glaucoma ☐ Other: _____
3. **Ear, Nose, Throat** ☐ **None** ☐ Hearing Loss ☐ Ear ache or infection ☐ Ringing in ear ☐ Other: _____
4. **Cardiovascular** ☐ **None** ☐ Chest Pain ☐ Swelling in Legs ☐ Palpitations ☐ Other: _____
5. **Respiratory** ☐ **None** ☐ Shortness of Breath ☐ Wheezing, Asthma ☐ Frequent Cough ☐ Other: _____
6. **Gastrointestinal** ☐ **None** ☐ Acid Reflux ☐ Nausea or Vomitting ☐ Abdominal Pain ☐ Other: _____
7. **Musculoskeletal** ☐ **None** ☐ Muscle Aches ☐ Swelling of the Joints ☐ Stiffness in Joints ☐ Other: _____
8. **Skin** ☐ **None** ☐ Rash ☐ Ulcers ☐ Abnormal Scars ☐ Other: _____
9. **Neurological** ☐ **None** ☐ Headaches ☐ Dizziness ☐ Numbness, tingling, loss of sensation ☐ Other: _____
10. **Psychiatric** ☐ **None** ☐ Depression ☐ Nervousness ☐ Anxiety ☐ Mood Swings ☐ Other: _____
11. **Endocrine** ☐ **None** ☐ Excessive thirst or hunger ☐ Hot/cold intolerance ☐ Hot flashes ☐ Other: _____
12. **Hematologic** ☐ **None** ☐ Easy Bruising ☐ Easy Bleeding ☐ Anemia ☐ Other: _____

Height: _____ **Weight: _____**

What activities would you like to do if you were not injured or in pain?

_____

_____

Signature: _____ **Date: _____**

Name: _____

Practitioner's Initials and Date: _____