



Shoulder & Knee Clinic Manila

Center for Minimally Invasive Surgery

INITIAL EVALUATION FORM

NAME: _____

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

Date of Birth: _____

Occupation / job: _____

Contact numbers: _____

Did another doctor send you to us? Yes / No

If yes, please give name & address of that physician:

Where is your problem? (please circle)

Shoulder Knee

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 – just started hurting
- Sports (which sport?)
- Motor vehicle accident
- Work / job –

Is there a worker's compensation claim? Yes / No

Sports level: none / recreational / college / professional

Date of injury? _____

How long have you had symptoms?

_____ Days _____ Months _____ Years

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 pain at night? Yes / No

Does it awaken 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 imaging studies?

X-rays No / Yes Date: _____

MRI No / Yes Date: _____

CT Scan No / Yes Date: _____

Are you interested in surgery to correct your problem?

Please circle one: No / Yes / Unsure

Allergies to medication(s)? _____

Do any diseases run in your family? _____

Medical History: (please circle)

Do / did you have any heart problems? No / Yes

Do / did you have ulcers / gastritis? No / Yes

Do / did you have blood pressure problems? No / Yes

Do / did you have diabetes? No / Yes

Do / did you have liver problems, hepatitis? No / Yes

Do / did you have thyroid problems? No / Yes

Do / did you have kidney disease? No / Yes

Do / did you have blood clots? No / Yes

Do / did you smoke? No / Yes

Other? (please use back of sheet as necessary)