WESTERN ORTHOPAEDICS
Excellence in Motion
1830 Franklin Street, Suite 450
Denver, CO 80218

Initial Patient Evaluation Form

Brian J. White M.D.
Orthopaedic Surgeon – Specialist in
Sports Medicine

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: _____

WESTERN ORTHOPAEDICS
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Brian J. White, MD
Hip Intake Form

Name:_____
MR#:_____
Date:_____

Do you have pain with any of the following?

1.	Long Sitting?	Yes	No
2.	Long Driving or Travel?	Yes	No
3.	Cycling?	Yes	No
4.	Putting on shoes and socks?	Yes	No
5.	Walking?	Yes	No
6.	Running?	Yes	No
7.	Pivoting/Twisting?	Yes	No
8.	Squatting?	Yes	No

Do you have any of the following mechanical symptoms? (Please circle symptoms if Yes)

Giving way - Giving out - Catching - Painful popping - Non-painful popping

Pelvic Floor Questions:

1.	Do you have pain or discomfort with intercourse?	Yes	No
2.	Do you have bladder problems such as incontinence or urinary urgency?	Yes	No
3.	Do you have difficulty or pain with bowel movements?	Yes	No
4.	In addition to your hip pain do you have a deep pain near the sit bone area?	Yes	No
5.	Females: Have you had children?	Yes	No

Please circle all the areas where you are having pain?

Groin - Bikini line - Side of hip - Buttock - Front of thigh Other: _____

Have you had any injections?

1. Into the side of hip or bursa? Yes No
   If yes, how long was it helpful? _____
   What percentage of your symptoms did it take away? _____%
2. Into the hip joint by x-ray? Yes No
   If yes, how long was it helpful? _____
3. What percentage of your symptoms did it take away? _____%

Medications

1. Have you taken any anti-inflammatories or Tylenol? Yes No
2. How long, specifically, have you been taking them (not just as needed)? _____
3. Did you develop any issues/side effects from taking it? Yes No

   If yes, please explain: _____

   _____
4. Please indicate what dosage and frequency: _____

_____

Physical Therapy?

1. Have you done Physical Therapy for this? Yes No
2. Where did you go? _____
3. How long did you attend? _____
4. Did it completely fix the problem? Yes No
5. Have you done massage or chiropractic work? Yes No

How are you presently feeling?

1. My pain consistently negatively impacts my mood and overall life satisfaction. Yes No
2. Losing my identity as an athlete (someone who is active) and not being able to exercise has been really challenging for me. Yes No
3. I am struggling with not knowing how to relieve my stress now that I cannot exercise like I used to. Yes No
4. I am unclear how to accept my new "disability status" even if it may be temporary. Yes No
5. I fear the uncertainty of what my future holds, wondering if this is my "new normal" and whether I will ever be without pain again. Yes No

Practitioner's notes:

Practitioner's initials and date: _____/_____