

Steadman Hawkins Clinic - Denver General

We appreciate you taking time to fill out the following information. Your answers will help us provide you with our best quality care. A computer reads the following forms. Therefore, please follow the instructions carefully. If you feel that you need to provide us with additional information, please **DO NOT** write it on the forms. Instead, feel free to discuss the information with the clinical staff when you are called back to the examination room.

Some questions allow you to mark **ALL** appropriate answers, and others ask for the **ONE** best answer. Please pay careful attention to the instructions. We are glad you have chosen us to take care of your orthopaedic needs.



10090

What body part are we seeing you for today (example: right hip, left knee...)

Grid for body part description

Location of Your Worst Problem (if you are here for more than 1 problem, which ONE is the worst)

Grid for location of worst problem

What are your main symptoms? (check all that apply) Please fill in the circle below your worst symptom (only circle one).

- Pain, Stiffness, Weakness, Unstable or slipping sensation, Dislocation, Popping, Tearing, Numbness/Tingling, Swelling

Date problem began (approximate if unsure)

If this a re-injury: Date of ORIGINAL injury

Month/Day/Year grid

Month/Day/Year grid

What do you think caused your symptoms? Spontaneous, Over use, Specific Injury, Accident, Unknown, Other (specify)

If your problem is the result of an injury, where did it occur? (check one answer only)

- Home, Work, Sport Competition, Exercise, Weight lifting, Motor vehicle accident, Other (specify)

What type of movement were you doing at the time your problem started? (check all that apply)

- Lifting, Throwing, Reaching, Pulling, Fall, Twisting, Collision/Contact, Other (specify)

What were you doing specifically when your problem started (ex. running up a flight of stairs, moving a box, skiing...)?

Grid for specific activity description

Check any of the following that happened at the time of your injury

- Felt pain, Heard popping, Had swelling, Dislocation, Fracture, Other (specify)

If you play an organized sport, what sport?

What position do you play?

Grid for sport name

Grid for position name

Level: Pro, Amateur, College, Recreational, High School, Junior High, Little League, other

Please check all other sports and activities in which you participate:

- Skiing, Snowboarding, Hiking, Bicycling, Running, Swimming, Football, Baseball, Basketball, Soccer, Golf, Tennis, Hockey, Cheerleading, Gymnastics, Lacrosse, Volleyball, Wrestling

Have you ever had any other significant injury to this same area in the past? If yes, give details:

- No, Yes, If yes, did you recover fully? Yes, No

Have you talked to a lawyer about today's problem? Did your problem start at work?

Are you receiving or have you applied for workers compensation concerning your problem?

Case Manager's Name: Grid

Have you previously had today's problem evaluated by (Check all that apply):

- Primary care physician, Another orthopaedic surgeon, Emergency room visit

Date of ER Visit

Month/Day/Year grid

Hospital of ER Visit: Grid

Treatment in ER: X-Rays, oral medicine, splint, brace, sling, crutches, fracture set, other

Have you received previous treatment (other than Emergency Room) for your current problem?

If yes, please specify treatment type (check all that apply) and provide the # of the procedures or weeks of physical therapy you have had for the specific problem you are seeing the doctor for today

- pain medicine, anti-inflammatory, physical therapy, manipulation, injections, chiropractic, acupuncture, ultrasound, surgery, massage therapy, cast, immobilization/sling, rest, ice application, other (specify)

Which Pain Medications have you taken for today's problem?

Grid for pain medications

Please provide the dosage

Grid for dosage

How often?

- once a day, twice a day, every 4-6 hours, as needed

Anti-inflammatories taken for today's problem?

Grid for anti-inflammatories

Please provide the dosage

Grid for dosage

How often?

- once a day, twice a day, every 4-6 hours, as needed



Review of Systems

Please check all problems you currently experience - **You must check AT LEAST one answer for each category, marking "none of the above" if you experience no problems in that area.**

Overall General Health

- recent weight gain
- recent weight loss
- appetite change
- difficulty sleeping
- none of the above

Endocrine & Metabolic

- sugar diabetes
- goiter
- thyroid problem
- cholesterol / lipid problem
- none of the above

Blood (Hematopoietic / Lymphatic / Immune)

- anemia
- lymph node enlargement
- bleeding problem
- frequent infections
- none of the above

Psychiatric

- anxiety
- depression
- been seen by a psychiatrist
- none of the above

Skin and/or Breast

- rash
- lesions on skin
- lump in breast
- discharge from nipple
- none of the above

Eyes

- change in vision
- red eye
- eye pain
- glaucoma
- none of the above

Ears, Nose, Throat, Mouth (ENT)

- earaches
- nose bleeds
- buzzing in ears
- hoarseness
- hearing loss
- taste change
- sinusitis / nasal stuffiness
- none of the above

RECENT TESTS (within 6 months)

Have you had recent blood tests? No Yes

If yes, give details: _____

Have you had a recent EKG? No Yes

If yes, give details: _____

Have you had a recent Chest X-Ray? No Yes

If yes, give details: _____

Kidney, Bladder, Reproductive (Genitourinary)

- burning on urination
- bloody urine
- frequency of urination
- sexual difficulties
- difficulty starting urine
- none of the above
- wetting pants or bed

Are you pregnant? Yes No

(Must answer for X-Ray purposes)?

Lungs (Respiratory / Allergy)

- allergies
- bronchitis
- cough
- shortness of breath
- sputum
- night sweats
- asthma
- none of the above

Heart & Blood Vessels (Cardiovascular)

- chest pain
- palpitations (irregular heart beat)
- heart attack
- edema (leg swelling)
- heart failure
- leg cramps with walking
- high blood pressure
- none of the above

Abdomen (Gastrointestinal)

- heartburn / indigestion
- black bowel movements
- difficulty swallowing
- change in bowel habits
- stomach pains
- constipation
- ulcers
- frequent laxative use
- nausea / vomiting
- jaundice or hepatitis
- diarrhea
- liver trouble
- hemorrhoids
- gallbladder problems
- rectal bleeding
- none of the above

Brain, Nerves, Spinal Cord (Neurologic)

- headaches
- paralysis
- dizziness
- convulsions / seizures
- blackouts
- coordination trouble
- numbness and tingling
- none of the above

Bone & Joint (Musculoskeletal)

- joint pain
- weakness
- joint swelling or warmth
- back pain
- joint stiffness
- joint deformity
- muscle pain
- none of the above

X-Rays/Tests for problem:

- Plain X-Rays / /
- MRI / /
- CT Scan / /
- Bone Scan / /
- Arthrogram / /
- Other (specify) _____ / /

Date of test

Did you bring the X-Rays or study with you today? Yes No

IN ORDER TO INSURE PROPER AND COMPREHENSIVE CARE, YOU MUST FOLLOW-UP WITH YOUR PRIMARY CARE PHYSICIAN FOR ANY AND ALL MEDICAL PROBLEMS AND CONCERNS CHECKED HERE.



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Please check any of the following conditions you have or have had in the past. If you are unsure, please ask a staff member to assist you in filling out this form. You may check more than one condition.

Medical Condition History Check this box if you have no medical problems [] no medical problems

- Alcoholism, Anemia, Anxiety, Asthma, Arthritis - rheumatoid, Arthritis - osteo, degenerative, Blood Clot, Blood Transfusion, Bowel disease, Cancer, Cardiac Arrhythmia, Congestive Heart Failure, Coronary Artery Disease, Cerebrovascular Disease, COPD, Diabetes, Depression, Fibromyalgia, GERD, Gout, Heart Attack, Hypertension, Hypercholesterolemia, Hypothyroidism, Kidney Disease, Liver Disorder - Cirrhosis, Liver Disorder - Hepatitis, Lung Disease, Osteomyelitis, Parkinson's, Ulcer Disease, Other

Surgery/ Procedures These are non-orthopaedic procedures. Please check any procedures you have had and give the year.

Have you ever had surgery? Yes No Year

Ear, Nose, Throat Surgeries

- Deviated Septum, Sinus Repair, Tonsillectomy, Tracheostomy, Vocal Cord Surgery

Gastrointestinal Surgeries

- Appendectomy, Cholecystectomy, Colon Resection, Exploratory Laproscopy

- Hernia (Femoral, Incisional, Inguinal, Umbilical)

- Liver Resection, Small Bowel Obstruction Repair, Splenectomy

Gynecologic Surgeries

- Hysterectomy, Oophorectomy, Ruptured ectopic, Laprascopy, C-Section

Urologic Surgeries

- Bladder Suspension, Bladder Removed, Lithotripsy, Prostatectomy, Vasectomy

General Surgeries

- Breast Biopsy, Mastectomy, Thyroid Surgery, Whipple

Heart (Cardiac) Surgeries

- CABG, Valve, Angioplasty, Defibrillator, Pace Maker

Vascular Surgeries

- Bypass Graft - Legs, Vascular Access, AAA, Thoracic Aneurysm

Thoracic Surgeries

- Chest Tube, Pulmonary, Pectus

Neurosurgeries

- Brain Tumor, Brain Aneurysm, Chiari Decompression, Spinal Cord Tumor, Epidural Injection, Abscess, Stent



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Orthopaedic Surgery/ Procedures Please check any procedures you have had and give the year.

Check this box if the procedure was for today's problem

Most Recent Year

Previous Surgery Year

(if same surgery performed more than once)

Broken Bones/Fracture Repair Surgeries

- Fracture Repair - Finger Right Left Bilateral
- Fracture Repair - Hand Right Left Bilateral
- Fracture Repair - Wrist Right Left Bilateral
- Fracture Repair - Arm Right Left Bilateral
- Fracture Repair - Elbow Right Left Bilateral
- Fracture Repair - Shoulder Right Left Bilateral
- Fracture Repair - Hip/Pelvis Right Left Bilateral
- Fracture Repair - Femur Right Left Bilateral
- Fracture Repair - Knee Right Left Bilateral
- Fracture Repair - Lower Leg Right Left Bilateral
- Fracture Repair - Ankle/Foot Right Left Bilateral

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Ankle/Foot Surgeries

- Ankle Arthroscopy Right Left Bilateral
- Ankle Fusion Right Left Bilateral
- Tendon Surgery Right Left Bilateral
- Toe Surgery specify _____ Right Left Bilateral

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Elbow, Wrist, Hand Surgeries

- Biceps Repair Right Left Bilateral
- Carpal Tunnel Surgery Right Left Bilateral
- Elbow Arthroscopy Right Left Bilateral
- Elbow Ligament Reconstruction Right Left Bilateral
- Elbow Replacement Right Left Bilateral
- Hand Tendon Repair Right Left Bilateral
- Nail Bed Surgery Right Left Bilateral
- Tennis Elbow Surgery Right Left Bilateral
- Trigger Finger Surgery Right Left Bilateral
- Wrist Ligament Reconstruction Right Left Bilateral

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Knee Surgeries

- Knee Arthroscopy Right Left Bilateral
- Cartilage surgery/meniscus surgery Right Left Bilateral
- Knee replacement Right Left Bilateral
- Ligament reconstruction - ACL Right Left Bilateral
- Ligament reconstruction - other Right Left Bilateral

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Hip Surgeries

- Hip replacement Right Left Bilateral
- AVN Surgery Core Decompression Fibular Graft Right Left Bilateral

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Shoulder Surgeries

- Shoulder Arthroscopy Right Left Bilateral
- Rotator cuff surgery Right Left Bilateral
- Shoulder replacement Right Left Bilateral
- Shoulder stabilization Right Left Bilateral

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Spine Surgeries

- Laminectomy Cervical Lumbar Thoracic
- Anterior Fusion Cervical Lumbar Thoracic
- Posterior Fusion Cervical Lumbar Thoracic
- Posterior Discectomy Cervical Lumbar Thoracic

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Other (List all other surgeries)



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Drug Allergy and Medication Information

Have you ever had problems with anesthesia? Yes No *If yes, describe* _____

Are you allergic to latex? Yes No

Are you allergic to any medications? Yes No *If yes, please write the name of the drug in the boxes below and check the reaction you experienced. Please write only one drug in each space provided. If you have more than 3 drug allergies list the others in the space provided.*

Specify Drug:

Describe: shock breathing problems rash nausea other _____

Specify Drug:

Describe: shock breathing problems rash nausea other _____

Specify Drug:

Describe: shock breathing problems rash nausea other _____

Please list additional drug allergies here: _____

Please list the medications you are currently taking - *Please include prescription and non-prescription medication*

Please check any anti-inflammatory medication listed below which you have taken in the past. *Please include all prescription, non-prescription and samples*

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Advil | <input type="checkbox"/> Naprelan |
| <input type="checkbox"/> Arthrotec | <input type="checkbox"/> Naproxen |
| <input type="checkbox"/> Bextra | <input type="checkbox"/> Oruval/Orudis |
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Daypro | <input type="checkbox"/> Ultram |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Vioxx |
| <input type="checkbox"/> Indocin | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Lodine | |

Please check any of the following side effects you experienced while taking any of the above anti-inflammatory medications.

nausea diarrhea gastric ulcers upset stomach vomiting other _____

Please check any of the following medications you take on a regular basis.

Aspirin Coumadin Heparin Maalox Mylanta Pepcid Prevacid Prilosec Tagamet Zantac

Family Medical History

Please check all diseases for which you have a family history:

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer - Breast | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Family health history is unknown |
| <input type="checkbox"/> Cancer - Prostate | <input type="checkbox"/> Arthritis - osteo, degenerative | |
| <input type="checkbox"/> Cancer - Other | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spine Problems | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Gout | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Lupus | |

If you know your parents' health history please provide the information below. Otherwise, please leave blank.

Father alive deceased *Age (current age or age deceased)*

- Health Problems:**
- | | |
|--|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> osteoarthritis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> gout |
| <input type="checkbox"/> stroke | <input type="checkbox"/> lupus |
| <input type="checkbox"/> diabetes | |

Mother alive deceased *Age (current age or age deceased)*

- Health Problems:**
- | | |
|--|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> osteoarthritis |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> gout |
| <input type="checkbox"/> stroke | <input type="checkbox"/> lupus |
| <input type="checkbox"/> diabetes | |

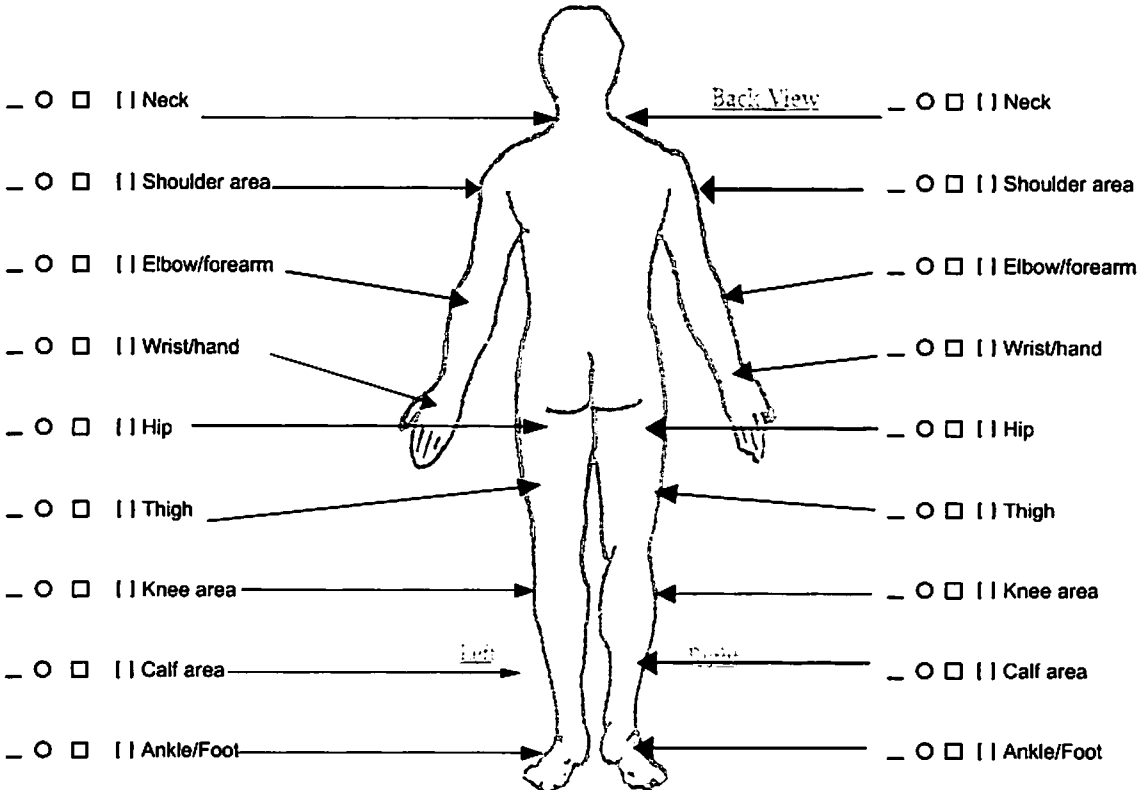
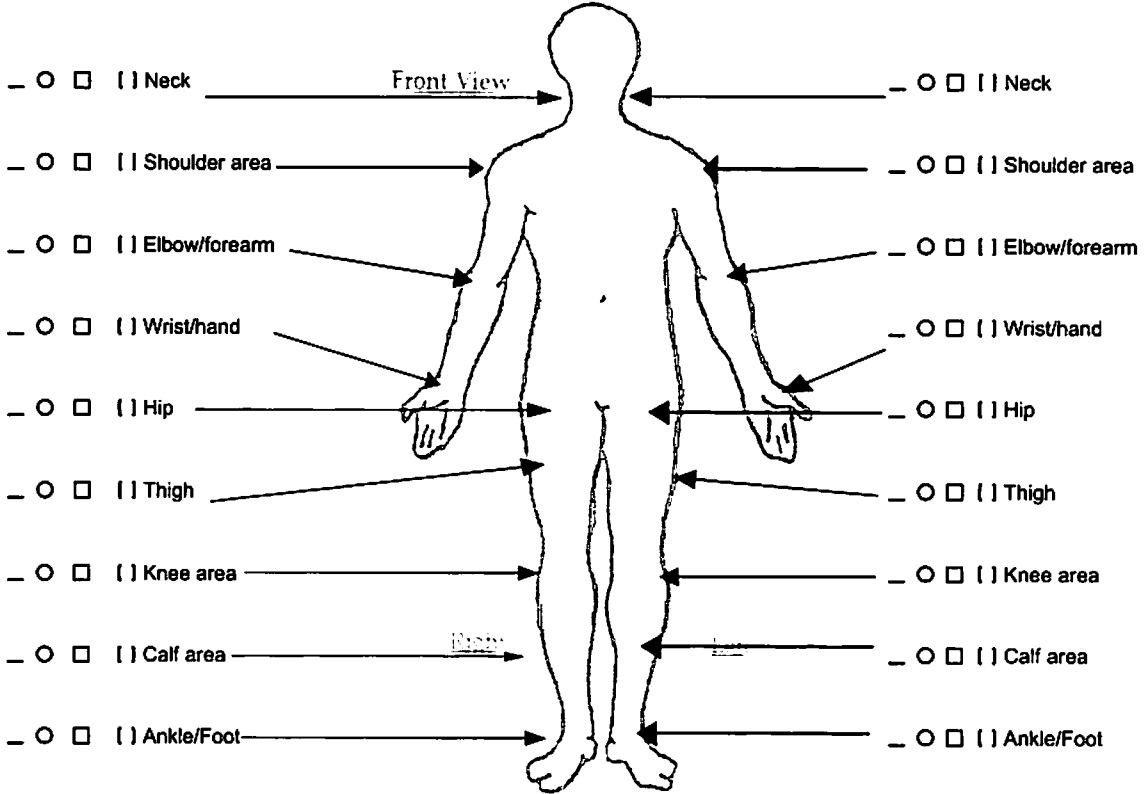


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Hand Dominance: Right Left Use both equally

Please place an X on the areas where you feel the sensations described below. Include all affected areas.

Aching Numbness Pins and Needles Burning





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SF-12 - Check ONLY ONE answer for each question

Instructions: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

(#2 and #3) The following items are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

- | | <u>Yes,
Limited
A Lot</u> | <u>Yes,
Limited
A Little</u> | <u>No, Not
Limited
At All</u> |
|--|-----------------------------------|--------------------------------------|---------------------------------------|
| 2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Climbing several flights of stairs | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

(#4 and #5) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 4. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 5. Were limited in the kind of work or other activities | <input type="radio"/> 1 | <input type="radio"/> 2 |

(#6 and #7) During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- | | <u>Yes</u> | <u>No</u> |
|---|-------------------------|-------------------------|
| 6. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 7. Didn't do work or perform other activities as carefully as usual | <input type="radio"/> 1 | <input type="radio"/> 2 |

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

(#9, #10 and #11) These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks

- | | <u>All
of the
time</u> | <u>Most
of the
time</u> | <u>A good
bit of
time</u> | <u>Some
of the
time</u> | <u>A little
of the
time</u> | <u>None
of the
time</u> |
|---|--------------------------------|---------------------------------|-----------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| 9. Have you felt calm and peaceful? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 10. Did you have a lot of energy? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |
| 11. Have you felt downhearted and blue? | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 |

12. During the past 4 weeks, how much of the time has your physical or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)?

- | <u>All
of the
time</u> | <u>Most
of the
time</u> | <u>Some
of the
time</u> | <u>A little
of the
time</u> | <u>None
of the
time</u> |
|--------------------------------|---------------------------------|---------------------------------|-------------------------------------|---------------------------------|
| <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 |

X _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

X _____
DATE

X _____
DOCTOR'S INITIALS