Mr Nadim Aslam Initial Clinic Evaluation Form

Consultant Knee, Sports Medicine and Hip Surgeon

Name: _____ **Date:** _____

Date of birth: _____ **Age:** _____

Occupation: _____ **Referring GP:** _____

Where is your problem? ☐ Shoulder ☐ Knee ☐ Elbow ☐ Neck ☐ Back ☐ Other

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
☐ Motor vehicle accident
☐ Work / job

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, physiotherapy, 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 waken 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? date:
☐ MRI? date:
☐ CT? scan date:

Are you interested in surgery to correct your problem? ☐ No ☐ Yes ☐ Unsure

Allergies to medication(s)?

Do any diseases run in your family? ☐ Yes ☐ No

Medical History:

heart problems?	☐ Yes	☐ No
ulcers / gastritis?	☐ Yes	☐ No
diabetes?	☐ Yes	☐ No
liver problems?	☐ Yes	☐ No
kidney disease?	☐ Yes	☐ No
blood clots?	☐ Yes	☐ No
hepatitis?	☐ Yes	☐ No
cancer?	☐ Yes	☐ No
smoker?	☐ Yes	☐ No