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INITIAL PATIENT EVALUATION FORM

Name: ……

Age: …… .. **DOB:** ..……/……/…..… **Marital status:** ……

Occupation/Job: …….. **Today's date:** ……..

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)

- o Pain?
- o Weakness?
- o Instability/Giving way/Dislocation?
- o Stiffness
- o Swelling?
- o Other?

……

……

How did you injure yourself?

- o No injury, just started hurting
- o Sports (which sport?) ……..
- o Motor vehicle accident?
- o Work / Job Is there a workers comp claim? Yes / No

Date of injury? ……

../2

How long have you had symptoms? ……

Briefly describe your injury: ……

……

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

Sports level: None / Recreational / Competitive

Surgical history (any surgery, not just orthopaedic surgery)

Problem + Date or Age	Treatments + Doctor	Successful (Y/N)
.....	……	……
……	……	……
……	……	……

How severe is the pain? (0 = none, 10 =severe pain) (circle relevant)

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

Quality: Sharp Dull Throbbing Aching
Stabbing Cramping Burning Stiffness

Timing: Constant Comes and goes Wakes from sleep
With exercise After activity

Makes it worse: Standing Sitting Walking Lifting
Twisting Bending Motion Squatting
Kneeling Stairs

Makes it better: Rest Ice Heat Motion
Elevation Massage Medicine Therapy

…/3

Other symptoms:	Swelling	Numbness	Catching	Loss of Motion
	Tingling	Clicking	Bruising	Weakness
	Locking			
What tests have been done:		X-rays	MRI	EMG/NCS
		Bone scan	Other ……	

What medications have you tried? ……..

……

Other treatments and therapy? ……

……

Are you currently working? Yes / No / Retired

If yes: normal job limited duty

Impact on capacity to work: ……..

……

What are your current working hours: ……

……

What duties are you currently performing: ……..

……

Is your claim accepted? Yes / No / Unsure

Are you allergic to latex? Yes / No

Allergies to medications or food? ……

…….. ……..

Current medications:
(prescription, over the counter, herbal health products, vitamins or dietary supplements

Name	Dose	Frequency
1. ……..	…….	…….
2. ……..	…….	…….
3. ……..	…….	…….
4. ……...	…….	…….
5. ……..	…….	…….
6. ……..	…….	…….
7. ……...	…….	…….
8. ……...	…….	…….
9. ……..	…….	…….
10. ……..	…….	…….
11. ……..	…….	…….
12. ……..	…….	…….

Do you take Aspirin? Yes / No

Past medical history: (please circle any illnesses that you have been treated for. Items not circled are understood to be negative)

Abnormal bleeding	Pneumonia	Cancer	Diabetes
Heart disease	Ulcer	Hepatitis	Kidney disease
Anaemia	Arthritis	Osteoporosis	Liver disease
Asthma	Gout	Anxiety	Emphysema
Phlebitis	Stroke	Tuberculosis	Hypertension
Rheumatic fever	Blood clot	Back/neck injury	AIDS/HIV +
Thyroid disorder	Epilepsy/seizure	Peripheral vascular disease	Polio

Other ……..

Height: …….. **Weight:** ……..

Do you smoke? Yes / No **How many a day?** …….. **How many years?** …….

Do you drink alcohol? Yes / No **Frequency?** ……

Are you pregnant? Yes / No

Family history: (please circle any conditions your family members have. Items not circled are understood to be negative)

Abnormal bleeding	Pneumonia	Cancer	Diabetes
Heart disease	Ulcer	Hepatitis	Kidney disease
Anaemia	Arthritis	Osteoporosis	Liver disease
Asthma	Gout	Anxiety	Emphysema
Phlebitis	Stroke	Tuberculosis	Polio
Rheumatic fever	Blood clot	Back/neck injury	AIDS/HIV +
Thyroid disorder	Epilepsy/seizure	Peripheral vascular disease	

Other: ……. None: ……..

Have you had any recent episodes of: (please circle. Items not circled are understood to be negative)

Fever	Weight loss	Shortness of breath	Swelling
Visual changes	Vomiting	Diarrhoea	Rashes
Hearing loss	Chest pain	Joint pain	Depression
Frequent urination	Hot flashes	Frequent infection	Inflammation
Blood in urine	Blood in stool	Anxiety	None