

**Boulder Orthopedics, P.C**  
**Sonja Stilp, M.D.**

**Patient Name:** \_\_\_\_\_

**EVALUATION FORM**

Page 1 of 2

**DEMOGRAPHICS**

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: Male/Female Handedness: Right/Left  
 E-mail address: \_\_\_\_\_

Language Barriers:	Can you understand English? Y___ N___	Can you read English? Y___ N___	1 <sup>st</sup> language preference _____
Primary Care Physician: Referring Physician:	List other treating physicians: _____		

**REASON FOR TODAY'S VISIT**

Reason? \_\_\_\_\_  
 When did it start? \_\_\_\_\_ How did it start (any injury)? \_\_\_\_\_  
 What specifically do you want to accomplish with today's visit? \_\_\_\_\_

<b>PAST MEDICAL HISTORY</b> <b>Major active health condition</b> <i>(check all that apply)</i> _____ heart disease _____ diabetes _____ lung disease _____ high blood pressure _____ kidney or liver problems _____ cancer (type) _____ _____ stroke _____ thyroid problems _____ seizures _____ arthritis _____ depression _____ asthma _____ heartburn _____ ulcers _____ migraines _____ other (please list) _____	<b>PAST SURGICAL HISTORY</b> <i>(include dates)</i> _____ _____ _____ <b>FAMILY MEDICAL HISTORY</b> Do you have a family history of <i>(circle all that apply)</i> Diabetes Rheumatoid arthritis Lupus Stroke Heart disease Back problems Other _____
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**MEDICATIONS** (Include doses, and all over the counter medications and herbal supplements)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES AND ADVERSE DRUG REACTIONS**

(circle all that apply and list the reaction)  
 \_\_\_\_\_ Penicillin, Sulfa, Contrast Dye, Other \_\_\_\_\_

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_ Status: (Circle One) Full-time / Part-time / Restricted-Duty / Off-Duty to Injury / Retired / Not working  
 Last Date of Employment: \_\_\_\_\_  
 Tobacco use: (Circle One) Current / Never / Quit Packs per Day: \_\_\_\_\_ How many years: \_\_\_\_\_  
 Alcohol use: (Circle One) Y N Drinks per week: \_\_\_\_\_

**PAIN**

Do you have pain that you want to discuss with your doctor? Y N  
 Site of Pain: \_\_\_\_\_

Quality (circle all that apply): dull /sharp /stabbing /burning /achy /throbbing /shooting/ squeezing/pressure/crampy

Using the pain scale below, please rate how bad your pain is today:

0 1 2 3 4 5 6 7 8 9 10  
 No Pain Mild Pain Mod Pain Severe Pain Very Severe Worst Possible

When did the pain start? \_\_\_\_\_  
 What medications have you tried or are currently using to control your pain? \_\_\_\_\_  
 \_\_\_\_\_  
 What medications **BEST** control your pain? \_\_\_\_\_  
 \_\_\_\_\_  
 How much you take a day? \_\_\_\_\_  
 Amount increased, decreased or same recently? (circle)

**EVALUATION FORM**

**PAIN HISTORY:**

What makes the pain *worse*? (Circle all that apply)  
Other \_\_\_\_\_

What makes the pain *better*? (Circle all that apply)  
Other \_\_\_\_\_

Is this related to a fall or MVA? Y N

Is this a work-related injury? Y N

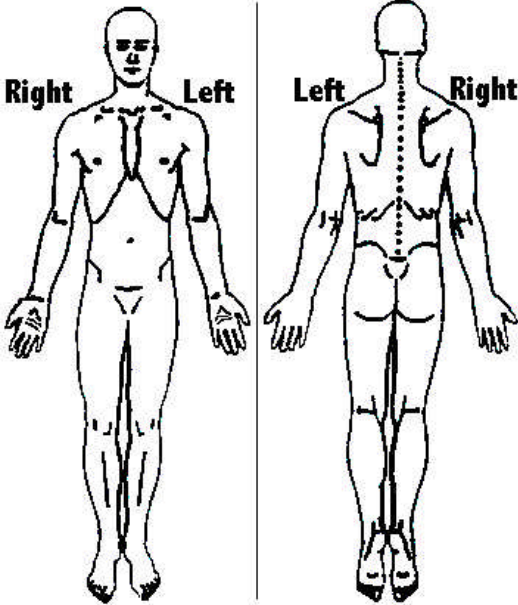
Is there litigation pending? Y N What tests have you had:

Which treatments have you tried for this problem:  
(Circle treatments and check helpful ones):  
Please list specific dates and details of treatment:

Did any of the treatments provide pain relief? Y N  
If so, which treatment and for how long? \_\_\_\_\_

Sitting Coughing	Standing Sneezing	Driving Walking	Lying Running	Twisting Bending <i>Forward/back</i>
Sitting	Standing	Walking	Lying	Moving
X-rays <i>Date? _____</i>	EMG <i>Date? _____</i>	MRI <i>Date? _____</i>	CT Scan <i>Date? _____</i>	
PT Chiroprctr	Acupunctr Injections	TENS Braces	Massage Exercise	Mind/body Surgery

**Please draw the location of your discomfort**



Do you have?	Yes	No
Difficult swallowing		
Headache or visual change		
Chest pain or palpitations		
Shortness of breath or asthma		
Nausea, vomiting, black stools		
Loss of bowel or bladder control		
Urinary or prostate/gynecologic issues		
Rashes		
Dizziness		
Depression		
Sleep problems		
Easy bleeding or on blood thinners		
Numbness and/or tingling		
<i>If yes, where?</i>		
Weakness		
<i>If yes, where?</i>		
Prior musculoskeletal problems		
<i>If yes, where?</i>		

**NUTRITION/EXERCISE**

**Have you ever had?** (check all that apply)  
 \_\_\_ Inability to eat or difficult with swallowing/chewing?  
 \_\_\_ Special diet requirements?  
 \_\_\_ Are you pregnant or lactating?  
 \_\_\_ Unintentional weight loss or gain?

**Do you have a regular exercise routine?** Yes No  
 (check all that apply) # times/week \_\_\_\_\_  
 Strengthening Stretching Walking Running Biking  
 Skiing/snowboarding Yoga Pilates Other (list) \_\_\_\_\_

**LEARNING/EDUCATION**

**Are there any?** (check all that apply)  
 \_\_\_ Cultural/social/spiritual barriers to learning about your condition  
 \_\_\_ Physical barriers to learning about your condition  
 \_\_\_ I want to learn more about my medical condition(s)? Y N

How do you learn best? (circle)  
 Verbal Demonstration Written Visual  
 Highest grade completed: (circle)  
 Grade School High School Postgraduate

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Initials of Reviewing Nurse: \_\_\_\_\_  
 Initials of Reviewing Physician: \_\_\_\_\_