PROLIANCE SURGEONS®

OPA ortho™

INJURY EVALUATION FORM

Sara Jurek, M.D.

seattleshoulderdoc.com | sarajurekmd.com

Name______________________________ Age________ Date_______

Involved body part______________ __Right __Left __Both – __Right worse __Left worse

When did your problem start? __________ Was there an injury? __Yes __No

Describe what happened (i.e. got hit, twisted skiing, over time)

____

If injured, did you feel/hear a pop? __Yes __No Did it swell? __Yes __No

When did it swell? __Immediately __Several Hours __Next Day Does it swell now? __Yes __No

If not injured, what activity do you think caused/contributed to the problem? ______________________

____

Do you have? __locking __clicking __catching __looseness/instability __stiffness/loss of motion

__weakness __sharp pain __aching

Pain is located on? ___ Front __Back __Inside (toward other side) __Outside (away from other side)

What makes pain worse? __twisting __running __up stairs __down stairs __kneeling __squatting

__standing after being seated __sleeping (pain awakens you)

What makes pain better? __ice __rest __medication __brace __orthotics __injections

How severe is the pain on average? (none) 0 1 2 3 4 5 6 7 8 9 10 (extreme)

Medications taken for this __Ibuprofen/Advil __Naproxen/Aleve __Other__________________

Injections? __Cortisone __PRP __Joint Lubricant date(s)__________________________

Percent improvement with injection(s)_________________

Previous treatment for this problem: __physical therapy __brace __orthotics __surgery

Previous Surgery Date Surgeon

____

____

____

Previous injuries to this body part/date(s) ______________________________________

____

Have you had __X-ray __MRI __Other test ______________________________for this condition

Sports/recreational activities____

Level of sport __High School __College __Professional __Other ______________________

Occupation____

Current School and Grade Level____

Goals after treatment for this problem______________________________________