Ernest L. Sink, MD
Center for Hip Preservation

INITIAL EVALUATION FORM

Name:____ Age:________ Date:____________

Accompanied by: ____________________________

Did another doctor send you to us? Yes / No

Occupation / job?__________________________________

Name of provider & Complete Address:

____

Involved Site? Shoulder Hip Knee Other:____________

Which side(s)? Right / Left / Both

Dominant hand/arm? Right / Left

Problem(s) (Please check all that apply): ☐Pain ☐ Weakness ☐ Instability/dislocation ☐ Stiffness ☐Swelling ☐ Other:____________
☐ Buckling ☐ Locking ☐ Grinding ☐ Clicking ☐ Catching

Difficulty with functional activities: ☐Walking ☐Stairs ☐Running ☐Squatting ☐Pivoting/twisting ☐Sitting w/ knee bent
☐Sitting for long time w/ hip flexed ☐Lifting objects ☐ Other:__________________________

How did you injure yourself? ☐No Specific Injury ☐Sports Related__________ ☐Auto-DOA:__________ ☐Work-DOI:__________

Sports level: ☐ None ☐ Recreational ☐ College ☐ Professional

How long have you had symptoms/pain? ______Days ______Weeks ______Months ______Years

Briefly describe your injury:____

Location of your pain:____

Given diagnosis (if known):____

Non-surgical treatments (ie; injection, physical therapy, etc)____________________________

Previous surgery for this injury:____

Severity of Pain: None Mild Moderate Severe

Pain Worse With:____

Pain Better With: ____

Do you have pain at night? Yes No Does it wake you up at night? Yes No

Are you currently working? Yes No Retired Full Duty Limited Duty

Do you have any imaging studies? X-rays MRI CT Scan

Please list ALL Allergies:____

Do you have any of the following medical conditions: (please circle): Heart problems Ulcers Diabetes Cancer Seizures
Liver Problems/Hepatitis Kidney Disease Blood Clots Asthma
Sleep Apnea Stroke Other:________________________

Please list all medications including over the counter medications and herbal supplements:________________________

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Reviewed by Dr. Ernest L. Sink: ____________________, M.D.