Tufts Medical Center Department of Orthopaedics
GENERAL EVALUATION FORM

(Please answer all questions **front and back** of form as best you can)

Name: ________________________________ **Date**: __________ **Age:** ______Height_______ Weight______
Cell Phone: _________________ **Home Phone** ___________________ **Work phone**: __________________

CHIEF COMPLAINT: (Why are you here today?)____

HISTORY OF INJURY: (What happened?) ____
What was the date of your injury? (How long has it bothered you?)___________________________________
Were you hurt at work? ☐ Yes ☐ No
What makes your problem better? ____
What makes your problem worse?____
Are you ☐ right-handed ☐ left-handed?
Who referred you to the Orthopaedic clinic? ____
Have you had any other treatment for your problem? (ice, rest, medications, physical therapy, alternative modalities?) ____

PAST MEDICAL HISTORY (list all health problems): ____
____
____

PAST SURGICAL HISTORY (list all previous surgeries): ____
____
____

MEDICATIONS: (Please list here or make sure medication reconciliation form has been completed)

ALLERGIES/REACTIONS:(medication or latex allergy?)____

REVIEW OF SYSTEMS

Are you currently or have you had problems with: (please circle "no" or "yes" and describe all "yes" answers)

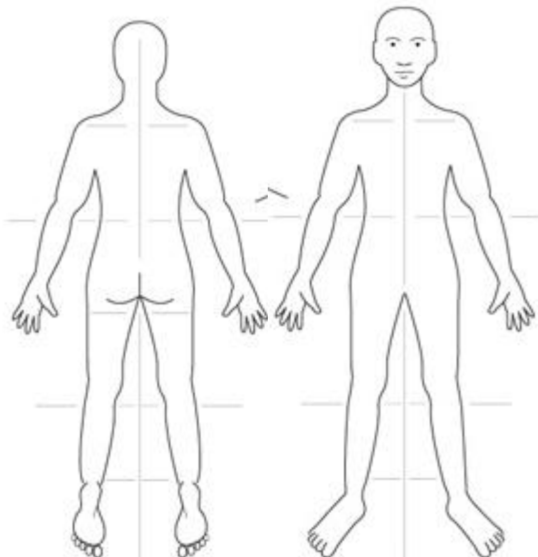
Ear, Nose, Throat:	No	Yes	________________________________
Eyes:	No	Yes	________________________________
Lungs, Breathing:	No	Yes	________________________________
High Blood Pressure/heart disease:	No	Yes	________________________________
Digestion, stomach:	No	Yes	________________________________
Bowel or Bladder problems:	No	Yes	________________________________
Diabetes:	No	Yes	________________________________
Bleeding Problems/blood clots:	No	Yes	________________________________
Numbness or tingling:	No	Yes	________________________________
Blackout or fainting:	No	Yes	________________________________
Psychological problems	No	Yes	________________________________
AIDS/HIV/hepatitis:	No	Yes	________________________________
Cancer:	No	Yes	________________________________
Arthritis:	No	Yes	________________________________
TB:	No	Yes	________________________________
Epilepsy:	No	Yes	________________________________

SOCIAL HISTORY:
☐ Work in home ☐ Student ☐ Employed (Occupation) ___________________________________
Employer:____
☐ Single ☐ Married ☐Divorced Children? ☐ No ☐ Yes # of children ___________
Do you live alone? ☐ No ☐ Yes
Do you exercise? ☐No ☐Yes How often? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never
What type of exercise?____
Do you have a history of substance abuse? ☐No ☐Yes What?___________________________|
Do you smoke? ☐No ☐Yes How many packs per day_______________# years ________________
Do you drink alcohol? ☐ Daily ☐1-2 x week ☐1-2 x month ☐ 1-2 x year

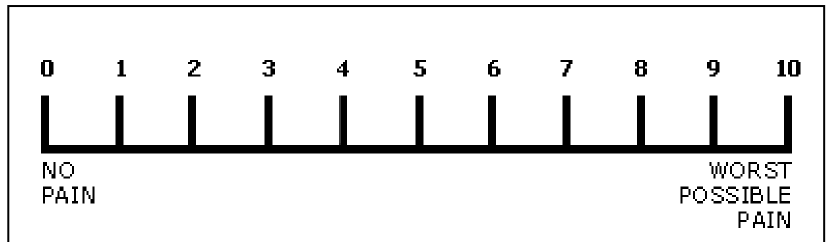
FAMILY HISTORY
Does anyone in your family have a history of blood clots/DVT? ☐ No ☐ Yes ____________________

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)				
Grandfather (mom's)				
Grandmother (dad's)				
Grandfather (dad's)				
Mother				
Father				
Brother/Sister				
Brother/Sister				
Child				

Please mark area where you have pain



Please rate your pain



Referring Physician: ______________________Primary Care Physician: _______________________
Emergency Contact Name and Telephone:____
Please send medical report to: (Physicians name and address): _________________________________
____