Shoulder Patient History

Medical Record Number: _ _ _ _ _ _ _
Today's Date: ___ / ___ / _____

_____ _____ _____ ____
First Name Last Name Middle Name Suffix

___ / ___ / _____ _ _ _ - _ _ - _ _ _ _____ _____ _____
Date of Birth Social Security # Gender Race Marital Status

Location of Problem: ☐Right Shoulder ☐ Right Elbow ☐Neck
☐Left Shoulder ☐ Left Elbow

If more than one, which is the worst?: _____

Date Problem Began (approximate): ____ / ____ / _____

Please describe your current problem:
☐ New injury or problem (less than 6 weeks duration)
☐ Subacute problem (6 weeks – 3 months duration)
☐ Chronic Problem (problem has been treated for more than 3 months and never returned to normal)
☐ Reinjury (you injured same area before, received treatment, had no problems until this new injury occurred)
-Date of Re-injury ____ / ____ / _____

Is your problem a result of an injury? ☐ Yes ☐ No

What caused your injury? ☐ Fall ☐ Fighting
☐ Lifting ☐ Twisting
☐ Throwing ☐ Collision/Contact
☐ Reaching ☐ Other: _____

Check any of the following that happened at the time of your injury:
☐ Felt pain ☐ Heard pop ☐ Had swelling ☐ Discoloration
☐ Dislocation ☐ Fracture ☐ Other: _____

If your problem is the result of an injury, where did it occur? (Check one answer)
☐ Home ☐ Work ☐Motor Vehicle Accident
☐ Exercise ☐ Sporting Competition ☐ Other: _____

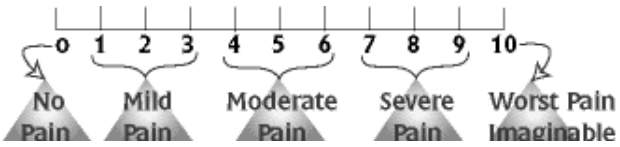
Have you talked to a lawyer concerning your injury? ☐ Yes ☐ No

Are you receiving or have you applied for workers compensation concerning your injury? ☐Yes ☐No

Have you received previous treatment for your current problem? ☐ Yes ☐ No (If yes, please specify)
☐ Medicine ☐ Physical Therapy ☐ Chiropractic ☐ Alternative
☐ Surgical (___ Number of surgeries) ☐ Injections (___ Number of injections)

Are you having pain today? ☐ Yes ☐ No Is your pain today: ☐ Occasional ☐ Constant

On a scale of 0 – 10, how would you score your pain today?



Check the words that best describe the character of the pain you are having today:
☐ Aching ☐ Nagging ☐ Exhausting
☐ Miserable ☐ Unbearable ☐Tender
☐ Stabbing ☐ Shooting ☐ Sharp
☐ Gnawing ☐ Penetrating ☐ Tiring
☐ Burning ☐ Numb

Does the pain awaken you from sleep? ☐ Never ☐ Occasionally ☐ Frequently
Does the pain keep you from falling asleep? ☐ Never ☐ Occasionally ☐ Frequently
What time of day is your pain worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ All the time

What makes your pain **better**:
☐ Rest ☐ Ice ☐ Sitting ☐ Lying Down ☐ Walking
☐ Medication ☐ Heat ☐ Standing ☐Nothing in particular ☐ Other: _____
What makes your pain **worse**:
☐ Rest ☐ Ice ☐ Sitting ☐ Lying Down ☐ Walking
☐ Medication ☐ Heat ☐ Standing ☐Nothing in particular ☐ Other: _____

Pease tell us your height and weight: **Height**: ___ feet ____ inches
Weight: _____ pounds

Referring Physician (first and last name): _____
Address: _____
_____

Review of Systems (Check any problems that apply in each category)

General
☐recent weight gain
☐recent weight loss
☐appetite change
☐difficulty sleeping ☐ None

Cardiovascular
☐chest pain
☐heart attack
☐palpitations (irregular heart beat)
☐heart failure
☐edema (leg swelling)
☐high blood pressure
☐leg cramps with walking ☐ None

Pulmonary
☐shortness of breath
☐cough
☐sputum
☐bronchitis
☐asthma
☐night sweats ☐ None

Endocrine & Metabolic
☐sugar diabetes
☐goiter
☐thyroid problem
☐sterility
☐cholesterol / lipid problem ☐ None

Hematopoietic / Lymphatic
☐anemia
☐lymph node enlargement
☐bleeding problem
☐frequent infections ☐ None

Musculoskeletal
☐joint pain
☐joint swelling or warmth
☐joint stiffness
☐muscle pain
☐weakness
☐back pain
☐joint deformity ☐ None

Gastrointestinal
☐heartburn / indigestion
☐difficulty swallowing
☐stomach pains
☐ulcers
☐nausea / vomiting
☐diarrhea
☐hemorrhoids
☐rectal bleeding
☐black bowel movements
☐change in bowel habits
☐constipation
☐frequent laxative use
☐jaundice or hepatitis
☐liver trouble
☐gallbladder problems ☐ None

Neurologic
☐headaches
☐dizziness
☐blackouts
☐numbness and tingling
☐paralysis
☐convulsions / seizures
☐coordination trouble ☐ None

Genitourinary
☐burning on urination
☐frequency of urination
☐difficulty starting urine
☐wetting pants or bed
☐bloody urine
☐sexual difficulties ☐ None

Psychiatric
☐anxiety
☐depression
☐been seen by a psychiatrist ☐ None

Past Medical History

·Please check any of the following conditions you have or have had in the past.
·If you are unsure, please ask a staff member to assist you in filling out this form.
You may check more than one condition.

☐ I have **no** medical problems
☐Alcoholism
☐Anemia
☐Anxiety
☐Asthma
☐Arthritis - rheumatoid (verified with blood test)
☐Arthritis - osteo, degenerative
☐Bowel disease
☐Cancer (specify)_____
☐Cardiac Arrhythmia (Abnormal heart rate)
☐Congestive Heart Failure
☐Coronary Artery Disease (Angina)
☐Cerebrovascular Disease (Stroke)
☐Diabetes
☐Depression
☐Hypertension (High Blood Pressure)
☐Hypercholesterolemia (Elevated Cholesterol)
☐Hypothyroidism
☐Kidney Disease
☐Liver Disorder (Cirrhosis, Hepatitis)
☐Lung Disease
☐Osteomyelitis
☐Parkinson's
☐Ulcer Disease
☐**Osteoprosis**
☐ Other (specify all other)_____
_____
_____

Have you ever had a blood transfuion? ☐Yes ☐ No
Have you ever had a blood clot? ☐Yes ☐ No

Past Surgical History

·Please check any of the following surgical procedures you have or have had in the past.

☐ I have **never** had surgery.

		Year of Most Recent Surgery	Year of Previous Surgery
☐Appendectomy			
☐CABG (Coronary Artery Bypass Grafting)			
☐Cholecystectomy (Removal of Gallbladder)			
☐Hysterectomy			
☐Mastectomy			
☐Herniorrhaphy (Hernia Repair)			
☐Tonsillectomy			
☐Splenectomy (Removal of Spleen)			
☐Discectomy - Cervical Spine			
☐Discectomy - Lumbar Spine			
☐Fusion - Cervical Spine			
☐Fusion - Lumbar Spine			
☐Fracture Repair – Ankle	☐Right ☐ Left ☐ Both		
☐Fracture Repair – Knee	☐Right ☐ Left ☐ Both		
☐Fracture Repair – Shoulder	☐Right ☐ Left ☐ Both		
☐Hip replacement	☐Right ☐ Left ☐ Both		
☐Arthroscopy – Knee	☐Right ☐ Left ☐ Both		
☐Cartilage surgery/meniscus	☐Right ☐ Left ☐ Both		
☐Ligament reconstruction – ACL	☐Right ☐ Left ☐ Both		
☐Ligament reconstruction – other	☐Right ☐ Left ☐ Both		
☐Knee replacement	☐Right ☐ Left ☐ Both		
☐Arthroscopy – Shoulder	☐Right ☐ Left ☐ Both		
☐Rotator cuff surgery	☐Right ☐ Left ☐ Both		
☐Shoulder replacement	☐Right ☐ Left ☐ Both		
☐Shoulder stabilization	☐Right ☐ Left ☐ Both		

☐Other (List all others) _____
_____
_____
_____
_____
_____

Family History

Please check all diseases for which you have a family history:

- ☐ Heart Disease
- ☐ Stroke
- ☐ Rheumatoid Arthritis
- ☐ Arthritis - osteo, degenerative
- ☐ Osteoporosis
- ☐ Cancer - Breast
- ☐ Cancer - Prostate
- ☐ Cancer - Other
- ☐ Diabetes
- ☐ Problems with anesthesia

☐ Reviewed and Unremarkable

Social History

Current Employment:

☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Unemployed ☐ Disabled

Job Title: _____

Level of Education:

☐ Grade school ☐ High school/equivalent ☐ Some college ☐ College degree ☐ Graduate degree

Alcohol:

- ☐ I drink alcohol
- ☐ Rarely (less than 1 drink a month)
- ☐ Occasionally (1-4 drinks per month)
- ☐ socially (1-2 drinks per week)
- ☐ frequently (3-5 drinks per week)
- ☐ daily (at least one drink a day)
- ☐ I do not drink alcohol, but I used to drink
- ☐ I never drank alcohol

Tobacco:

- ☐ I have never used tobacco
- ☐ I currently smoke the following number of packs per day:
  - ☐ ½ ☐ 2
  - ☐ 1 ☐ 2½
  - ☐ 1½ ☐ 3
- -Years of tobacco use at this pattern: ____ yrs
- ☐ I do not use tobacco, but I used to use

Exercise. Do you exercise regularly? ☐ Yes ☐ No

How often? ☐ daily ☐ 3 times per week ☐ weekly ☐ at least once every other week

Allergies

Are you allergic to any medications? ☐ Yes ☐ No. Please list

_____
_____
_____
_____
_____
_____

Current Medications

Please list the medications you are currently taking - Please include prescription and non-prescription medication. Please list doses and number of times taken daily

_____
_____
_____
_____
_____
_____

Please check any **anti-inflammatory medication** listed below which you have taken in the past. Please include all prescription, non-prescription and samples provided.

- ☐ Advil
- ☐ Arthrotec
- ☐ Daypro
- ☐ Ibuprofen
- ☐ Lodine
- ☐ Naprelan
- ☐ Naproxen
- ☐ Celebrex
- ☐ Tylenol
- ☐ Ultram
- ☐ Other (specify)_____

Please check any of the following **side effects** you experienced while taking any of the above **anti-inflammatory medications**.

☐ Nausea ☐ Diarrhea ☐ Gastric ulcers ☐ Upset stomach ☐ Vomiting ☐ other_____

Please check any of the following medications you take on a regular basis.

☐ Aspirin ☐ Axid ☐ Coumadin ☐ Cytotec ☐ Heparin ☐ Maalox
☐ Mylanta ☐ Prevacid ☐ Pepcid ☐ Zantac ☐ Tagamet ☐ Prilosec

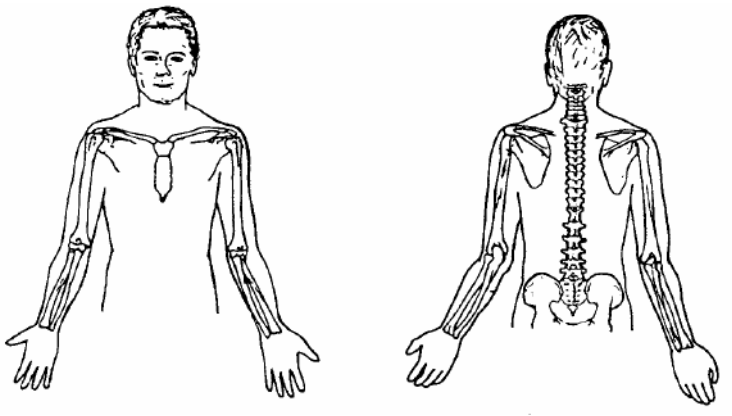
INITIAL SHOULDER QUESTIONNAIRE

TODAY'S DATE: _____

SELF EVALUATION

1. Hand Dominance: ☐Right ☐Left ☐Use both equally
2. Are you having pain in your shoulder? ☐Yes ☐No

Mark where your pain is on this diagram:



3. Do you have pain in your shoulder at night? ☐Yes ☐No
4. Do you take pain medication (aspirin, Advil, Tylenol, etc.)? ☐Yes ☐No
5. Do you take narcotic pain medication (codeine or stronger)? ☐Yes ☐No
6. Does your shoulder feel unstable (as if it is going to dislocate)? ☐Yes ☐No
7. How unstable is your shoulder? **(PLEASE MARK A NUMBER)**

Very Stable 0 1 2 3 4 5 6 7 8 9 10 Very Unstable

8. How would you rate your upper extremity today as a percentage of normal? _____%
(0% - 100%, with 100% being normal)

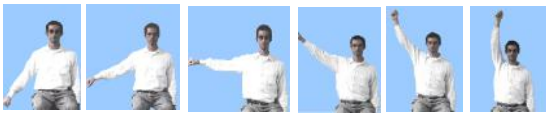
10. Do you have mechanical symptoms (catching, locking or grinding in your joint)? ☐Yes ☐No

RANGE OF MOTION -- Please mark the estimated motion of your shoulder for each of the 3 directions

☐ ☐ ☐ ☐ ☐ ☐

Forward Flexion – straight in front

Abduction – out to the side



☐ ☐ ☐ ☐ ☐ ☐

☐ ☐ ☐ ☐ ☐

Internal Rotation – reaching up your back

<u>IF YOU HAVE HAD SURGERY</u>, please answer the following questions. Otherwise, please leave them blank.

a. Does your operated arm feel numb in any region? ☐Yes ☐No
b. Does your operated arm feel weaker to any activity now than before? ☐Yes ☐No
c. Does your operated arm feel more painful now than before surgery? ☐Yes ☐No

d. Would you have the same procedure performed upon yourself again? ☐Yes ☐No

e. How would you rate your **personal satisfaction** with your surgery? (**circle one**)

Excellent Good Satisfactory Unsatisfactory

FUNCTION (AMERICAN SHOULDER AND ELBOW SOCIETY SCORE)

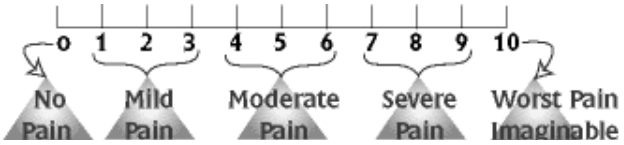
Please note your ability to do the following daily activities, or if you were to try such activities (Best Guess):

0 = **Unable** to do, 1 = **Very difficult** to do, 2 = **Somewhat** difficult, 3 = **Normal** (Check ONLY ONE answer)

	Right Arm	**Left Arm**
1. Put on a coat	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
2. Sleep on your affected side	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
3. Wash back/connect bra in back	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
4. Manage toileting	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
5. Comb hair	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
6. Reach a high shelf	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
7. Lift 10lbs above shoulder	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
8. Throw a ball overhead	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
9. Do usual work	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
(Please describe usual work): _____		
10. Do usual sport	☐0 ☐1 ☐2 ☐3	☐0 ☐1 ☐2 ☐3
(Please describe usual sport): _____		

PAIN

On the following scale of 0-10, please mark the average amount of pain you experience in your shoulder on a daily basis. **(PLEASE CIRCLE A NUMBER)**



FUNCTION

On the following scale of 0-10, please mark what you consider to be the current overall function of your shoulder.

0 = my shoulder is useless

10 = my shoulder is normal **(PLEASE CIRCLE A NUMBER)**

Useless 0 1 2 3 4 5 6 7 8 9 10 **Normal**

SIMPLE SHOULDER TEST

Answer each question below by checking "Yes" or "No":

1. Is your shoulder comfortable with your arm at rest by your side?	☐Yes ☐No
2. Does your shoulder allow you to sleep comfortably?	☐Yes ☐No
3. Can you reach the small of your back to tuck in your shirt with your hand?	☐Yes ☐No
4. Can you place your hand behind your head with the elbow straight out to the side?	☐Yes ☐No
5. Can you place a coin on a shelf at the level of your shoulder without bending your elbow?	☐Yes ☐No
6. Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?	☐Yes ☐No
7. Can you lift eight pounds (a full gallon container) to the level of your shoulder without bending your elbow?	☐Yes ☐No
8. Can you carry twenty pounds at your side with the affected extremity?	☐Yes ☐No
9. Do you think you can toss a softball under-hand 10 yards with the affected extremity?	☐Yes ☐No
10. Do you think you can toss a softball over-hand 20 yards with the affected extremity?	☐Yes ☐No
11. Can you wash the back of your opposite shoulder with the affected extremity?	☐Yes ☐No
12. Would your shoulder allow you to work full-time at your regular job?	☐Yes ☐No

SF-12 - Check ONLY ONE answer for each question

Instructions: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:
☐1 Excellent ☐2 Very good ☐3 Good ☐4 Fair ☐5 Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐ 1	☐ 2	☐ 3
3. Climbing several flights of stairs	☐ 1	☐ 2	☐ 3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like	☐1-Yes	☐ 2-No
5. Were limited in the kind of work or other activities	☐1-Yes	☐ 2-No

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like	☐1-Yes	☐ 2-No
7. Didn't do work or perform other activities as carefully as usual	☐1-Yes	☐ 2-No

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
☐1--Not at all ☐2--A little bit ☐3--Moderately ☐4--Quite a bit ☐5—Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks.

	All of the time	Most of the time	A good bit of the time	Some of the time	A Little of the time	None of the time
9. Have you felt calm and peaceful?	☐1	☐2	☐3	☐4	☐5	☐6
10. Did you have a lot of energy?	☐1	☐2	☐3	☐4	☐5	☐6
11. Have you felt downhearted and blue?	☐1	☐2	☐3	☐4	☐5	☐6
12. During the past 4 weeks, how much of the time has your physical or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)?	☐1	☐2	☐3	☐4	☐5	☐6