SHOULDER INFORMATION SHEET

Patient Name: ____ **Date Form Completed:** ________________________

Referred By: ____

Height: ____________ **Weight:** _____________

Sex: Male Female

Affected Shoulder: Right Left

Dominant Hand: Right Left Ambidextrous

Have you had a recent injury, fall or other accident:

Yes No **Explain:** ____

Briefly describe your shoulder problem: ____

____

Previous Shoulder Imaging (Check All Appropriate): MRI EMG Bone Scan CT Scan X-Ray

Occupation: ____

Heavy Manual Labor Light Manual Labor Sedentary Work

Usual Activities/Sports Include: ____

Where is Your Pain?

Please select your pain points on the image below.

Does anything make your pain :

Better: ___________________________________

Worse: ___________________________________

On a scale of 1-10, indicate your pain level:

1 2 3 4 5 6 7 8 9 10

Do you repeatedly move your shoulder in the same way on a daily basis (such as in sporting activities)?

Yes No

Has your shoulder been treated with any of the following?

Surgery Injections Physical Therapy Acupuncture

Chiropractic Medications None of the above

Did the pain start slowly or suddenly: Slowly Suddenly

When did your pain start? ____

Does the pain travel from your shoulder to other parts of your body?

If yes, where? ____

When do you experience pain (Check any that apply):

At rest During activity At night (wakes me up) Raising my arm above my shoulder

Have you noticed a loss of strength? Yes No

Do you feel you have lost mobility for doing things like putting your hand in back pocket, combing your hair or putting a coat on? Yes No

Does it hurt when you lie on the affected side? Yes No

Does your shoulder feel like it could "pop out" of the socket? Yes No

Do you hear a "clicking" sound when you move your shoulder? Yes No

Is your shoulder tender to the touch? Yes No

Any other pertinent information related to your shoulder pain that we should be aware of: __________________

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MEDICAL DATA SHEET

Patient Name____**Date:**_______________________

Past Medical History (Mark all that apply)

○ Diabetes	○ Asthma	○ Cancer ________________
○ High Blood Pressure	○ Emphysema/COPD	○ Seizures
○ Atrial Fibrillation	○ Pulmonary Embolism	○ Stroke
○ Heart Attack	○ Sleep Apnea	○ Arthritis
○ Other Heart Problem ___________	○ Other Lung Problem ____________	○ Rheumatoid Arthritis
○ Anemia	○ Kidney Disease	○ Osteoporosis
○ Blood Clots/Phlebitis	○ Urinary Infections	○ Gout
○ Bleeding Disorders	○ Acid Reflux/GERD	○ Fibromyalgia
○ Liver Problems	○ Stomach Ulcers	○ Chronic Pain
○ Hepatitis (type ________________)	○ Anxiety	○ Reaction to Anesthesia
○ Thyroid Problems	○ Depression	○ History of MRSA Infection
○ HIV/AIDS	○ Currently Pregnant	○ Other_________________________

Primary Care Provider: ____

Other Providers: ____

Past Surgical History

Surgery	Year	Doctor

Current Medications

Medication Name	Strength	How many pills at a time	Times per day

Patient Name____**Date:**______________________

Allergies/Reactions to Medications, Latex, Sutures, Metal, Etc.

Allergy	Reaction

Social History

Smoking:	Never	Former (year quit____________)	Current (packs/day_____________)
Alcohol:	Never	Rarely	Occasionally	Daily

Family History

Cancer	Heart Disease	Arthritis	Reaction to Anesthesia	Abnormal Bleeding/Clotting
Explain:				

Advance Care Plan: Do you have a Living Will or Medical Power of Attorney? ________________________

Review of Systems (Please circle all conditions or symptoms that you *currently* experience)

General	Fevers Weight Changes Abnormal Sweats Fatigue Dizziness
Skin	Rash Infections Bruise Easily Itching Skin Growths
Eyes/Ears/Nose/Throat	Vision Loss Blurred Vision Dentures Hearing Loss Difficulty Swallowing
Respiratory	Cough Shortness of Breath Wheezing
Cardiovascular	Chest Pain Irregular Heartbeat Lower Leg Swelling
Endocrine	Sweating Excessive Thirst Excessive Urination
Gastrointestinal	Bloody Stools Constipation Diarrhea Nausea Vomiting Abdominal Pain
Urinary	Incontinence Urgency Frequency Hesitancy
Neurological	Frequent Headaches Numbness Tingling Weakness
Musculoskeletal	Fractures Joint Pain Joint Swelling Muscle Aches
Emotional	Anxiety Depression

____
Patient/Designee Signature Date

____
Physician/PA Signature Date

Date reviewed with patient:

________________ ________________ ________________ ________________ ________________

________________ ________________ ________________ ________________ ________________