

Patient Questionnaire: Shoulder

Name: _____ Age: _____ Date: _____ Acct.# _____

Which hand is your dominant hand? Right Left

Which shoulder has pain? Right Left Both

When did your present pain start (approximately what date)? _____

Was there a related injury/accident? Yes No Please explain _____

Please describe how your pain started: No apparent cause

Have you had similar pain in the past? Yes No If yes, when? _____

Where is the pain located? Inside Outside Front Back
Please indicate how severe your pain is now (0=no pain to 10=worst pain) _____

Which of the following activities produces pain?

working overhead reaching forward sleeping always hurts

Does the pain wake you up at night? Yes No

Does the pain go past your elbow? Yes No

Do you have any numbness/tingling in your hands? Yes No

Do you have any neck pain/problems? Yes No Please explain _____

Have you noticed any clicking or popping of you shoulder? Yes No Please explain _____

Which of the following treatments have you used?

ice/heat NSAIDS (Motrin, Aleve, Celebrex) Tylenol physical therapy

Cortisone Injection None

How much relief was provided? _____ How long did it last? _____

Name: _____ Age: _____ Date: _____ Acct.# _____

Medical History None

High Blood Pressure Diabetes Hypothyroidism Coronary Art Disease

Angina/MI Arrhythmia COPD Emphysema Asthma

Renal Failure Ulcers Cancer Arthritis SLE (lupus)

Rheumatoid Arthritis Seizures Clots (DVT) Blood Disorders

Other _____

Surgical History (including dates): None

Current Medications None

Allergies None

Do you have difficulty taking Antiinflammatory medications? Yes No

Social History

Tobacco use: Yes No if yes, packs per day _____ and years of use _____

Alcohol use: Yes No if yes, amount per week _____

Job description/School Attending: _____

Work Status: Are you Employed Unemployed Disabled Retired?

Marital Status _____ # of children _____

Family History

Please list any significant medical problems in your family

Name: _____ Age: _____ Date: _____ Acct.# _____

Review of Systems

Check all that apply to your health

Constitutional

- Fever, Chills, Sweats
- Weight loss
- Change in appetite
- Excessive fatigue
- None of the above

Eyes, Ears, Nose, & Throat

- Recent changes in vision
- Glaucoma
- Metal fragments in eyes
- Nosebleeds
- Hearing loss
- Poor balance
- None of the above

Cardiovascular

- Chest pain or Angina
- High blood pressure
- Heart murmur
- Irregular pulse
- Elevated Cholesterol
- Calf pain when walking
- None of the above

Respiratory

- Sleep apnea
- Asthma, wheezing
- COPD
- Chronic cough
- Blood in sputum
- Lung Cancer
- Pneumonia or bronchitis
- None of the above

Gastrointestinal

- Ulcer or gastritis
- Nausea or vomiting
- Jaundice or liver problems
- Gallbladder problem
- GERD/heartburn
- Blood in stool
- Colon Cancer
- None of the above

Genitourinary

- Bladder infections
- Blood in urine
- Difficulty with urination
- Kidney stones
- Prostate problems
- Abnormal Pap smear
- None of the above

Musculoskeletal

- Swelling in multiple joints
- Excessive flexibility of joints
- Broken bones, which? _____
- Dislocated joints, which? _____
- Fibromyalgia
- Reflex Sympathetic Dystrophy
- None of the above

Skin

- Chronic rashes
- Eczema or Psoriasis
- Skin Cancer
- Breast lump/nipple discharge
- None of the above

Neurological

- Seizures
- Leg pain/sciatica
- Weakness of a limb
- Numbness of a limb
- Bowel/bladder control loss
- Stroke
- Loss of memory
- None of the above

Psychiatric

- Anxiety
- Depression
- Claustrophobia
- None of the above

Endocrine

- Diabetes
- Thyroid problems
- Hormone Replacement Therapy
- Taken Prednisone
- Anemia
- None of the above

Hematological/Immunology

- Easy bleeding/bruising
- Blood transfusions
- Decreased resistance to infection
- None of the above