

SHOULDER HISTORY

NAME: _____
Last Name First Name Middle Initial

DATE: _____

Please answer each of the following questions by checking as many responses as necessary. If the answer you need is not available, please feel free to write it in.

How old are you? _____

Which is your dominant arm? _____ Right _____ Left

What is your occupation? _____

Where do you live (city, state)? _____

Who referred you to our office? _____

With which shoulder are you experiencing difficulty? _____ Right _____ Left _____ Both
_____ Right worse than left
_____ Left worse than right

How long have you been experiencing difficulty with your shoulder? _____

What do you think may have caused your shoulder symptoms? (for example, spontaneous, over use, exercise, specific injury, an accident). Please explain: _____

Which of the following shoulder symptoms are you experiencing? Please check all that apply. Rank them in order of decreasing severity starting with one (1) as the most significant symptom.

- | | |
|--|--|
| <input type="checkbox"/> Pain. | <input type="checkbox"/> Popping. |
| <input type="checkbox"/> Stiffness. | <input type="checkbox"/> Tearing. |
| <input type="checkbox"/> Weakness. | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Instability/slipping sensation. | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Dislocation. | |

Where do you experience the majority of your shoulder discomfort?

- | | |
|---|---|
| <input type="checkbox"/> At the front of the shoulder | <input type="checkbox"/> On the side of the shoulder/upper arm |
| <input type="checkbox"/> At the top of the shoulder | <input type="checkbox"/> Generalized pain throughout the shoulder |
| <input type="checkbox"/> At the back of the shoulder | |

Does your shoulder pain radiate (move)?

- | | |
|--|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Into the front of your chest area |
| <input type="checkbox"/> Down your arm | <input type="checkbox"/> Into your upper back/shoulder blade area |
| <input type="checkbox"/> Up into your neck | |

Please check the shoulder discomfort that you are having:

- | | |
|----------------------------------|--|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Intermittent |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Present only with certain activities. |

Please mark the severity of the shoulder discomfort that you are having on a scale of 1 to 10 on the line below (1 = minimal, 10 = extremely severe).

1 _____ 5 _____ 10
Minimal Moderate Severe

Do you have difficulty reaching or moving your shoulder in any of the following directions:

- Overhead
- Out to the side
- Across your chest
- Behind your back
- Forward
- All directions

Does your shoulder problem interfere with any of the following:

- Daily activities
- Work activities
- School activities
- Recreation or sports activities

Please explain: _____

Do you experience shoulder pain at night which interferes with your sleep? Yes No

Have you previously had your shoulder evaluated by

- Primary care physician
- Another orthopedic surgeon
- Emergency room visit

Please check any treatments that you have tried for your shoulder condition?

- Rest
- Ice application
- Anti-inflammatory medications (which ones) _____
- Pain medication
- Cortisone injection
- Immobilization/sling
- Physical therapy
- Other _____

Has the treatment helped?

- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No

Have you ever had shoulder surgery in the past? Yes No

If yes, please explain: (date, doctor, procedure if known) _____

Have you had any of the following imaging studies for your shoulder?

- X-ray
- MRI
- Arthrogram
- CT scan
- Bone scan
- Other _____

How is your shoulder progressing?

- Getting better
- Getting worse
- Staying about the same

Have you ever had any other significant shoulder injury in the past? Yes No

If yes, please explain _____

If yes, did you recover fully? Yes No

Please list any other information you feel would assist your doctor with your treatment.
