

NAME: _____
Last Name First Name Middle Initial

DATE: _____

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

Have you had any of the following imaging studies for your shoulder? Please include dates, if known.

- X-ray
- MRI
- CT Scan
- Bone Scan
- Other _____

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

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

Has treatment helped?

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

How is your shoulder progressing? Getting better Staying the same Getting worse

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

If yes, please explain: _____

If yes, did you fully recover? Yes No

Have you ever had shoulder surgery Yes No

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

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

