Premier Orthopedics

Shoulder History

Name: _____ Age: _____

Occupation: _____

Which shoulder is involved: (Check One) ☐ Right ☐ Left ☐ Both

When did symptoms first appear? Date: _____

How did symptoms occur? (Check one)

- ☐ Injury (what happened) _____
- ☐ Spontaneous
- ☐ Arm pain then shoulder pain
- ☐ Neck pain then shoulder pain
- ☐ Other

If injured, how did injury occur? (Check all that apply)

- ☐ Sports related: Which sport _____
- ☐ Fall or direct injury to shoulder
- ☐ Motor Vehicle Accident
- ☐ Injury to neck or arm, and then shoulder pain
- ☐ Other (describe) _____

What treatments have you had? (Check all that apply)

Who evaluated pain? Name: _____
Name: _____

☐ X-rays Date: _____
Results: _____

☐ MRI or CAT Scan Date: _____
Results: _____

Past Medications, for Shoulder (please list) _____
_____

Please list any anti-inflammatory medications you currently take: _____
_____

Are you taking any anti-spasm medication? ☐ No ☐ Yes (if yes please list) _____
_____

Have you had any physical therapy for your shoulder: If yes, where? _____
Dates: From: _____ To: _____

Have you had any injections to your shoulder? Dates: _____

Please list any surgeries (Date & Type i.e. arthroscopy, reconstruction)

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____

Current Symptoms: _____

_____

What is the level of your pain? (Check one in each column)

☐ Mild	☐ Dull	☐ No ache
☐ Moderate	☐ Sharp (Knife-like)	☐ Intermittent ache
☐ Severe	☐ Burning	☐ Constant ache

Where is the pain located? (Check all that apply)

- ☐ Front of the shoulder
- ☐ Back of the shoulder
- ☐ Side of the shoulder
- ☐ Neck
- ☐ Arm

What makes the shoulder pain worse? (Check all that apply)

- ☐ Any use of arm ☐ Sports only ☐ Any sleeping position
- ☐ Any activity when hand is above shoulder level
- ☐ Other _____

What improves pain? (Check all that apply)

- ☐ Physical therapy ☐ Injections ☐ Ice ☐ Heat ☐ Rest ☐ Surgery
- Medication: Type _____ Exercises: Type _____
- Other _____

What are your functional limitations?

- ☐ Unable to work
- ☐ Unable to do work above shoulder level-job is restricted
- ☐ Unable to comb hair
- ☐ Unable to perform in sports
  - Type of sports _____
- ☐ Unable to dress completely (i.e. shirt, coat, bra, etc.)
- ☐ Unable to perform heavy lifting only
- Other _____

Other bone or joint problems:

- ☐ Pain Where? _____
- ☐ Swelling Where? _____
- ☐ Surgery? _____

Patient Name _____