Patient **SHOULDER** Questionnaire

Name:________________________________ Date: ______________

Age: __________ Telephone:______________ Sex: ❑ Male ❑ Female

What kind of work do you do? ________________________________

Who referred you to this office (name of person)? ________________________

Which hand do you write or throw with? ❑ Right or ❑ Left

HISTORY:

1. Which shoulder is the problem? ❑ Right or ❑ Left
2. What is the problem (i.e. Pain or stiffness or dislocation, etc.) ________________
3. When did you start to have the problem? __________________________
4. Did you have an injury? ❑ Yes ❑ No If so, what was the injury? ______________

   ____
5. Have you seen another physician (Who) for this problem? ____________________
6. Have you had a shoulder problem before? ❑Yes ❑No If so, what and how was it treated? _

   ____
7. Have you dislocated your shoulder before? ❑Yes ❑No

   If so, how many times? ____________________________________

   How was the first dislocation treated? ____________________________

   ____
8. Have you had any injections into your shoulder? ❑Yes ❑No

   If so, how many times and when was the last time? ________________________
9. Have you had any shoulder surgery? ❑Yes ❑No If so, which shoulder, what and when performed and when and which doctor: ____________________________
10. What medicines do you take for your shoulder pain (list medication dose and frequency)?

    ____

<u>SYMPTOMS:</u>

1. Do you have any NECK PAIN? ____
2. Do you have shoulder pain that awakens you at night? ____________________________
3. Do you have pain <u>ALL</u> the time, <u>MOST</u> of the time, or only <u>SOME</u> of the time? (circle one)
4. Does the pain interfere with work? ❑Yes ❑No With sports? ❑Yes ❑No
5. Do you have any NUMBNESS, TINGLING, or PINS-AND-NEEDLES feeling in your arm or hand? ____
6. Have you missed any work due to this injury? ❑Yes ❑No If so, how long?______________
7. Activities or Sports you USUALLY participate in but are having difficulty doing so:

   ____