Orthopedic Patient Questionnaire: SHOULDER

Name: ______________________________ Gender: ☐ Male ☐ Female

Hand Dominance: ☐ Right ☐ Left ☐ Ambi

1. Which shoulder is bothering you? ☐ Right ☐ Left ☐ Both | Which one hurts worse? ☐ Right ☐ Left

2. When did your symptoms begin? (month/day/year) ______________________________

3. Were you injured? ☐ Yes ☐ No How were you injured? ______________________________
   Where: ☐ Work ☐ Home ☐ Other: ______________________________

4. Prior injuries or problems to your arm? ☐ Yes ☐ No When: ______________________________
   How were you injured? ______________________________
   Who treated you? ______________________________

5. Prior treatment for this injury? ☐ None ☐ Emergency Room | Hospital: ______________________________
   ☐ Doctor's office | Name: ______________________________

6. What was done? X-rays: ☐ Regular x-rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Other: ______________________________
   Medication: ☐ Anti-inflammatory ☐ Pain meds ☐ Cortisone shot
   Devices: ☐ Sling ☐ Shoulder immobilizer ☐ Brace ☐ Splint ☐ Cast
   Physical therapy: ☐ Yes ☐ No If yes, how long? ______________________________

6. Prior surgery to this shoulder? ☐ Yes ☐ None ☐ Arthroscopy ☐ Rotator cuff tear ☐ Decompression ☐ Fracture

8. Any neck pain? ☐ Yes ☐ No
9. Tingling down your arms? ☐ Yes ☐ No
10. Pain is *always* present? ☐ Yes ☐ No
11. Pain **without** motion of arm? ☐ Yes ☐ No
12. Loss of motion of shoulder? ☐ Yes ☐ No
13. Popping of shoulder? ☐ Yes ☐ No
14. Tearing sensation? ☐ Yes ☐ No
15. Weakness of the shoulder? ☐ Yes ☐ No
16. Burning down your arms? ☐ Yes ☐ No
17. Pain comes and goes away? ☐ Yes ☐ No
18. Pain **with** motion of arm? ☐ Yes ☐ No
19. Pain wakes me up at night? ☐ Yes ☐ No
20. Aching of shoulder area? ☐ Yes ☐ No
21. Pain lifting arm to (circle) ☐ **side** or ☐ **overhead**
22. Can lift arm to side or overhead? ☐ Yes ☐ No
23. Have you dislocated your shoulder? ☐ Yes ☐ No

24. Do you take medication or anti-inflammatory medicine? ☐ Yes ☐ No Type: ______________________________
    Number of pills an average per day? ____________ pills.

25. How bad is your pain today? (no pain) 0 ———————— 5 ———————— 10 (worse pain)

PATIENT LABEL

Initial Orthopedic Patient Questionnaire: SHOULDER

26. Does your shoulder feel unstable (as if it were going to dislocate)? ☐ Yes ☐ No

    How unstable is your shoulder today? (Mark line)

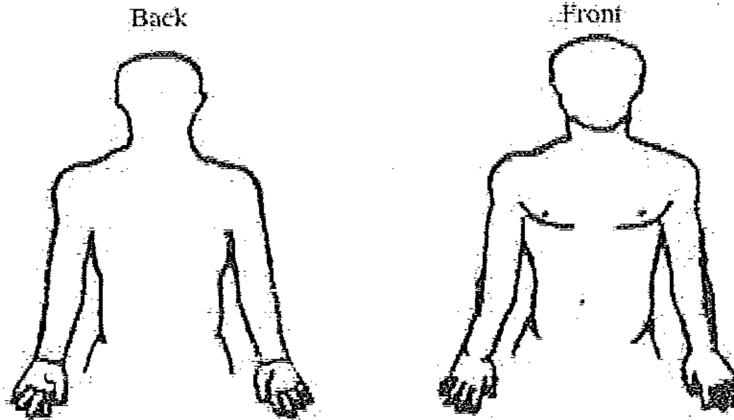
    (stable) 0 ———————— 5 ———————— 10 (very unstable)

27. Mark on the diagram the location of pain or sensation.

    Pain starts ——▶ Stops here X

Sensation type:

////////	Sharp stabbing
AAA	Aching
═══	Numbness
CCC	Catching
++++	Burning
PPP	Popping
*****	Pins & needles



Please return to receptionist when complete.

Patient Signature ____________________ Date ____________

If other than the patient, indicate relationship ____________________

Provider Signature ____________________ M.D./P.A.

PATIENT LABEL