

Today's Date: \_\_\_\_\_ Appointment Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Female  Male

Height: \_\_\_\_\_ feet \_\_\_\_\_ inches Weight: \_\_\_\_\_ pounds

**Primary Care Physician:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Referring Physician Name:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Reason for your visit today: \_\_\_\_\_

**Affected side:**

Right  Left  Both

**If both sides which side is worse?**

Right  Left

**Dominant Hand:**

Right  Left

**Location:**

neck  back

shoulder  hip

arm  thigh

elbow  knee

forearm  lower leg

wrist  ankle

hand  foot

**When do symptoms occur?**

night

morning

work

during activity

after activity

other \_\_\_\_\_

\_\_\_\_\_

**Quality of pain** (check all that apply)

Sharp  Electric Shocks

Dull  Constant

Burning  Intermittent

Throbbing

**What makes symptoms better?**

Rest

Heat

Brace/bandage/sling

Medications

Physical Therapy

Cold

Exercise

Other: \_\_\_\_\_

**Duration of symptoms?**

- 1-4 weeks
- 4-8 weeks
- 8-12 weeks
- other: \_\_\_\_\_ (days/months/years)

**Date of Onset:** \_\_\_\_\_

**Are your symptoms?**

- Improving
- Getting worse

**Injury:**

\_\_\_\_\_ No history of injury.

\_\_\_\_\_ History of injury as follows: \_\_\_\_\_

Have you noticed any of the following? (check all that applies)

\_\_\_\_\_ Swelling \_\_\_\_\_ # of occasions

\_\_\_\_\_ Dislocation (shoulder has popped out of place) \_\_\_\_\_ # of occasions

Did your shoulder get popped back in place? Yes / No

If yes, how? \_\_\_\_\_ Popped back by itself When? \_\_\_\_\_

If not by itself then how? \_\_\_\_\_

\_\_\_\_\_ Giving way (shoulder gives out) \_\_\_\_\_ # of occasions?

**Lifting is:**

- \_\_\_\_\_ Unlimited
- \_\_\_\_\_ Occasionally difficult
- \_\_\_\_\_ Always difficult
- \_\_\_\_\_ Impossible

**Overhead Activities are:**

- \_\_\_\_\_ Unlimited
- \_\_\_\_\_ Occasionally difficult
- \_\_\_\_\_ Always difficult
- \_\_\_\_\_ Impossible

**Sleeping at night is:**

- \_\_\_\_\_ Normal
- \_\_\_\_\_ Interrupted when I turn on my shoulder
- \_\_\_\_\_ Difficult regardless
- \_\_\_\_\_ Impossible

**I comb/brush my hair with:**

- \_\_\_\_\_ Ease
- \_\_\_\_\_ Difficulty
- \_\_\_\_\_ I cannot

**Reaching across my shoulder is:**

- \_\_\_\_\_ Pain free
- \_\_\_\_\_ Mildly painful
- \_\_\_\_\_ Painful
- \_\_\_\_\_ Impossible

**Public Transportation**

- \_\_\_\_\_ Used easily
- \_\_\_\_\_ Used with difficulty
- \_\_\_\_\_ Impossible

**Pain is localized to my shoulder:**

- \_\_\_\_\_ And my neck
- \_\_\_\_\_ And my upper arm
- \_\_\_\_\_ And forearm
- \_\_\_\_\_ And my fingers

**I can reach into my back pocket:**

- \_\_\_\_\_ Easily
- \_\_\_\_\_ With difficulty
- \_\_\_\_\_ Impossible with my involved arm

**PAST MEDICAL HISTORY**

**Brain**

- TIA (transient ischemic attack)

**Endocrine**

- Insulin dependent diabetes
- Non-insulin dependent diabetes
- Hypercholesterolemia
- Hypothyroidism

**Heart**

- Coronary artery disease
- Myocardial infarction  
(Heart Attack)
- Hypertension

**Infectious**

- HIV
- Hepatitis
- Cellulitis
- Syphilis
- Joint infection

**Kidney**

- Chronic renal failure

**Lung**

- Pulmonary embolism
- Chronic bronchitis
- Asthma
- COPD

**Musculoskeletal**

- Low back pain
- Sciatica
- Spinal Stenosis
- Degenerative disk disease
- Juvenile Rheumatoid Arthritis
- Lupus
- Rheumatoid Arthritis
- Psoriasis

**Cancer**

Type: \_\_\_\_\_  
\_\_\_\_\_

**Psychiatric**

- Alcohol abuse
- Major depression
- Anxiety disorder
- Bipolar disorder
- Schizophrenia

**Stomach and Intestine**

- GERD
- Gastric ulcer
- Irritable Bowel Syndrome

**Vascular**

- DVT
- Phlebitis
- Sickle cell anemia

**Other:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST ORTHOPAEDIC SURGICAL HISTORY**

<u>Past Surgeries</u>	<u>Side/Location</u>	<u>Year</u>	<u>Name of Surgeon</u>
<b>Joint Replacement</b>			
<input type="checkbox"/> Total Hip Replacement	Right Left Both	_____	_____
<input type="checkbox"/> Total Knee Replacement	Right Left Both	_____	_____
<input type="checkbox"/> Partial Knee Replacement	Right Left Both	_____	_____
<input type="checkbox"/> Core Decompression	Right Left Both	_____	_____
<input type="checkbox"/> High Tibial Osteotomy	Right Left Both	_____	_____

**Spine**

<input type="checkbox"/> Cervical (neck) Fusion	Levels _____	_____	_____
<input type="checkbox"/> Cervical Disc Removal/ Decompression	Levels _____	_____	_____
<input type="checkbox"/> Lumbar (lower back) Fusion	Levels _____	_____	_____
<input type="checkbox"/> Lumbar Disc Removal/ Laminectomy	Levels _____	_____	_____
<input type="checkbox"/> Kyphoplasty	Levels _____	_____	_____

**Sports**

<input type="checkbox"/> Knee Arthroscopy	Right Left Both	_____	_____
<input type="checkbox"/> Rotator Cuff Repair	Right Left Both	_____	_____
<input type="checkbox"/> Total Shoulder Replacement	Right Left Both	_____	_____

**Trauma** (List bone/joint and treatment)

_____	Right Left Both	_____	_____
_____	Right Left Both	_____	_____

**PAST SURGICAL HISTORY**

**Breast**

- Lumpectomy (left or right)
- Mastectomy (left or right)

**Gastrointestinal**

- Hernia repair
- Resection of large bowel
- Removal of Gall Bladder
- Dialysis shunt
- Varicose vein stripping
- Other: \_\_\_\_\_

**Cardiovascular**

- Pacemaker
- Coronary artery bypass
- Valve replacement

**Vascular**

- Abdominal aortic aneurysm
- Femoral Bypass

**SOCIAL HISTORY**

**Occupation**

- Employed
- Unemployed
- Student
- Work from home
- Retired

**Marital Status**

- Single
- Married
- Separated
- Divorced
- Widowed

**Athletics**

- Professional
- Amateur
- Recreational
- None

**Exercises**

- Daily
- Weekly
- Rarely
- Never

Sport \_\_\_\_\_ Type \_\_\_\_\_

Do you have a history of substance abuse?  No  Yes What? \_\_\_\_\_

Do you currently use illegal drugs?  No  Yes Past use?  No  Yes

What type? \_\_\_\_\_ Last used? \_\_\_\_\_

**ALCOHOL HISTORY**

Do you currently drink alcohol?  No  Yes. If yes, what type of alcoholic beverages do you usually drink?  Beer  Wine  Hard Liquor (such as whiskey, scotch, gin or vodka)

**CURRENT drinking history**

- Less than a month
- 2-4 times per month
- 2-3 times a week
- 4-5 times a week
- 6 or more times a week

**PAST drinking history**

- Less than a month
- 2-4 times per month
- 2-3 times a week
- 4-5 times a week
- 6 or more times a week

**How many drinks did you**

**have on a typical day**

**when you were drinking?**

- 1-2 drinks
- 3-4 drinks
- 5-6 drinks or more

**SMOKING HISTORY**

\_\_\_\_\_ I have never smoked.

Do you currently smoke?  No  Yes How long have you smoked? \_\_\_\_\_

I currently smoke:  1/4 pack  1/2 pack  3/4 pack  1 pack  2 packs per day

I quit smoking:  less than 1 year ago  more than 1 year ago  more than 5 years ago

**I formerly smoked:**    ¼ pack    ½ pack    ¾ pack    1 pack    2 packs per day  
**What type of tobacco did you smoke?**    Cigarettes    Cigars    Pipe

**MEDICATION INFORMATION** *Please check the medications you use:*

**High Blood Pressure**

- Accupril
- Atenolol
- Capoten (Captopril)
- Cardizem (Diltiazem)
- Cardura (Doxazosin)
- Cozaar (Losartan)
- Diovan (Valsartan)
- Vasotec (Enalapril)
- Zestril (Lisinopril)
- Lopressor/Toprol (Metoprolol)
- Lotensin (Benazepril)
- Norvasc (Amlodipine)
- Procardia (Nifedipine)

**Heart Medication:**

- Lanoxin (Digoxin)
- Nitroglycerin

**Blood Thinners:**

- Aspirin
- Coumadin (Warfarin)
- Plavix

**Cholesterol Lowering Drugs:**

- Lipitor (Atrovastatin)
- Pravachol (Pravastatin)
- Zocor (Simvastatin)

**Diuretic (Water pills):**

- Dyazide (HCTZ/triamterene)
- Lasix (Furosemide)
- Hydrochlorothiazide (HCTZ)

**Diabetes:**

- Glucophage (Metformin)
- Glucotrol (Glipizide)
- Insulin

**Gastrointestinal (Stomach):**

- Nexium (Esomeprazole)
- Prevacid (Lansoprazole)
- Prilosec (Omeprazole)
- Zantac (Ranitidine)

**Rheumatology:**

- Methotrexate
- Prednisone
- Plaquenil
- Enbrel

**NSAIDs:**

- Advil/Motrin (Ibuprofen)
- Aleve (Naproxen or Naprosyn)
- Celebrex
- Mobic

**Pain:**

- Tylenol (Acetaminophen)
- Tylenol #3
- Darvocet
- Dilaudid
- Ultram (Tramadol)
- Oxycodone
- Oxycontin
- Duragesic patch (Fentanyl)
- Endocet/Percocet/Tylox
- MS Contin (Morphine)
- Lortab/Vicodin (Hydrocodone)
- Neurontin

**Supplements:**

- Herbals
- Glucosamine
- Fish Oil
- Flax seed
- Ginko

**Other Medications:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES**

\_\_\_ **NO KNOWN DRUG ALLERGIES**

<u>Medicine</u>	<u>Reaction</u>	<u>General</u>	<u>Reaction</u>
___ Aspirin	_____	___ Latex	_____
___ Erythromycin	_____	___ Adhesive	_____
___ NSAIDS	_____	___ Other	_____
___ Penicillin	_____		
___ Sulfa	_____		

**REVIEW OF SYSTEMS** *Please mark the symptoms you are currently experiencing:*

**General**

- Good general health
- Chills
- Feeling tired all the time
- Dizziness
- Loss of appetite
- Fever
- Night sweats
- Weight gain of more than 10lbs
- Weight loss of more than 10lbs

**Skin**

- No problems
- Dryness
- Excessive sweating
- Rash

**HEENT**

- Blurry vision
- Sinusitis
- Fainting
- Headache

**Respiratory**

- Chest pain
- Shortness of breath
- Chronic cough
- Wheezing

**Cardiovascular**

- Chest pain
- Swelling in legs
- Night cramps
- Palpitations
- Phlebitis
- Skipped heartbeats

**Gastrointestinal**

- Anorexia
- Constipation
- Diarrhea
- Heartburn

**Neurological**

- Dizziness
- Headaches
- Incontinence stool
- Incontinence urine
- Loss of balance

**Psychiatric**

- Anxiety
- Change in sleep pattern
- Depression

**Endocrine**

- Frequent urination
- Appetite changes
- Cold intolerance

**Hematology**

- Anemia
- Easy bruising
- Enlarged lymph nodes
- Prolonged bleeding

**Male Genitourinary**

- Hesitancy
- Incontinence

**Neck**

- Difficulty swallowing

**FAMILY HISTORY**

<b><u>Family member</u></b>			<b><u>Age</u></b>	<b><u>Health status or cause of death</u></b>
Father	Alive	Deceased	_____	_____
Mother	Alive	Deceased	_____	_____

Additional information:

The questionnaire has been reviewed with the patient.

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**Physician/Resident/PA or Nurse's Signature**

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**Date**

**\*\*\*PATIENT IS TO STOP HERE\*\*\***

**Past Medical History:** The patient has completed and signed our comprehensive past and present medical history. It is documented in the chart. The nurse and myself have reviewed it. The patient is well nourished and in no acute distress.

**Physical Examination:** Temperature is °. Height is . Weight is lbs. Patient is well nourished and in no acute distress.

**Skin:** \_\_\_\_ There are no skin lesions  
 \_\_\_\_ Skin lesions include \_\_\_\_\_

<b><u>Palpation:</u></b>	<b>Right</b>	<b>Left</b>
Supraspinatus tendon	Nontender	Nontender
Biceps tendon	Nontender	Nontender
Coracoacromial ligament	Nontender	Nontender
AC Joint	Nontender	Nontender

**Shoulder: Range of Motion**

Flexion	180°	180°
Abduction	180°	180°
Internal rotation	T12	T12
External rotation	40°	40°

**Neck: Range of Motion**

Rotation	90°	90°
Flexion	Chin to chest	Chin to chest
Extension	Can see ceiling	Can see ceiling

**Motor Strength:**

Subscapularis	5+/5	5+/5
Supraspinatus	5+/5	5+/5

**Provocative Tests:**

Impingement sign	Negative	Negative
Impingement test	Negative	Negative
Secondary impingement	Negative	Negative
Drop arm test	Negative	Negative

**Instability:**

Anterior	None	None
Inferior	None	None
Apprehension	None	None
Sulcus	None	None

**Vascular Status:**

	<b><u>Right</u></b>	<b><u>Left</u></b>
Ulnar pulse	2+	2+
Radial pulse	2+	2+
Adson's test	2+	2+

**Studies:**

X-rays demonstrate a Type I \_\_\_\_, Type II \_\_\_\_, Type III \_\_\_\_ acromion.

\_\_\_\_\_ with \_\_\_\_\_ without AC joint arthritis. There \_\_\_\_\_ is \_\_\_\_\_ isn't any dislocation.

\_\_\_ MRI arthrogram

\_\_\_ MRI regular

\_\_\_ MRI is done and is:

\_\_\_ normal

\_\_\_ notable for a rotator cuff tendonitis

\_\_\_ torn rotator cuff

\_\_\_ slap lesion

\_\_\_ MRI is not available.

**Impression:**

**Plan:**

**Dictated: Michael E. Trice, M.D.**

Revised: 4/29/2008