DEARBORN & ASSOCIATES
INSTITUTE FOR JOINT RESTORATION

NEW SHOULDER PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Medical Record #: _____ Age:_____

Right-Handed / Left-Handed / Both (circle) Occupation:_____

Male / Female (circle) Is this injury work related? YES / NO (circle)

Referring MD (name/address): _____

HISTORY

1. Which SHOULDER is the problem? RIGHT LEFT BOTH (circle)
2. When did the pain begin? _____
3. Did you have an injury that caused the pain? _____ If yes, what injury and when? _____
   _____
4. Have you had a shoulder problem before? _____ If yes, when and how was it treated? (THERAPY, INJECTIONS, MEDICINES, SURGERY (circle all that apply) _____
   _____
5. If you had shoulder surgery before, please give details below:

SIDE	DATE (month/year)	PROCEDURE	SURGEON	IMPROVEMENT?
RIGHT				
LEFT				

6. Have you dislocated your shoulder before? _____ If yes, how many times and when? _____
   _____
7. If you have had injections into your shoulder, how many times? _____ When was the last? _____
8. What medicines are you taking NOW for shoulder pain? _____
   _____
9. What medicines have you tried in the PAST for your shoulder pain? _____
   _____
10. Do you have NECK pain that is severe or pain that shoots all the way down your arms? _____ If yes, which arm(s) does it go down? _____

SYMPTOMS

1. Do you have pain ALL the time, MOST of the time, or only SOME of the time? (circle)
2. Is the pain SHARP, DULL, ACHING, or OTHER? (circle). Is it CONSTANT, INTERMITTENT? (circle)
3. Does the pain awaken you at night while sleeping? _____
4. What activities make the shoulder hurt more? _____

5. Does reaching, lifting OVERHEAD or BEHIND YOUR BACK make the pain worse? (circle)
6. Do you have NUMBNESS, TINGLING, or a PINS-AND-NEEDLES feeling in your arm or hand? (circle)
   Which side(s)? _____

PAST MEDICAL HISTORY

1. What health problems do you have (circle from list and add as needed)? _____
   _____

   High blood pressure Diabetes Heart Disease Cholesterol Stomach Ulcers

   Hepatitis B Hepatitis C Abnormal Thyroid Bleeding Problems

2. Have you had ANY OTHER previous surgery? _____ If yes, please give details below:

   PROCEDURE DATE (month/year) PROCEDURE DATE (month/year)
   _____
   _____
   _____

3. What MEDICINES are you currently taking (will confirm with your chart)? _____
   _____
   _____
   _____

4. What medicines are you ALLERGIC to, and what happens (rash, anaphylaxis, bleeding, etc.)? _____
   _____

5. Do you SMOKE? ____ If yes, how many packs per day? ½ 1 1 ½ 2 >2 (circle)

6. Do you drink ALCOHOL? _____ If yes, how many drinks per day? < 1 1 2-3 4-6 >6 (circle)

7. Do you have medical problems in your FAMILY? Circle all that apply: _____
   High blood pressure Heart attack Diabetes Arthritis Bleeding disorder

   Cancer Premature death Epilepsy Sickle cell anemia Other problem _____

8. Review of systems. (Please circle all that apply to you):

General	Unexplained weight loss or gain Fevers Increased thirst
Skin	Rash Moles Scarring
Head	Frequent headaches History of concussions
Neck	Herniated disc "Whiplash"
Eyes	Blurry vision Pain Loss of vision
Ears/Nose/Throat	Nosebleeds Ringing Earache Sore throat
Respiratory	Shortness of breath Coughing Wheezing
Cardiovascular	Chest pain Irregular heart beat Swelling in hands or feet
Stomach	Pain Vomiting Bloody stool Diarrhea Heartburn
Urinary	Burning Blood in urine
Hematologic	Bleeding disorders Abnormal bruising
Nervous system	Seizures Stroke Aneurysm Loss of balance
Mental health	Depression Anxiety

