John G. Costouros, MD, FAAOS, FACS
Chief of Shoulder Surgery
Institute for Joint Restoration & Research

NEW SHOULDER PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: _____ Today's Date: _____

□ Male □ Female □ Right-Handed □ Left-Handed □ Both

Occupation: _____ Faith Tradition: _____

Referring MD (name/address): _____

HISTORY

1. Which SHOULDER is the problem? □ RIGHT □ LEFT □ BOTH
2. When did the pain begin? _____
3. Did you have an injury that caused the pain? □ Yes □ No If yes, what injury and when? _____

   _____
4. Have you had a shoulder problem before? □ Yes □ No If yes, when and how was it treated?
   □ THERAPY □ INJECTIONS □ MEDICINES □ SURGERY □ OTHER
   Details: _____
5. If you have had shoulder surgery before, please give details below:

   SIDE DATE (month/year) PROCEDURE SURGEON IMPROVEMENT?

   RIGHT

   _____

   LEFT

   _____
6. Have you dislocated your shoulder before? □ Yes □ No 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? □ Yes □ No
    If yes, which arm(s) does it go down? _____

SYMPTOMS

1. Do you have pain □ ALL the time □ MOST of the time □ only SOME of the time?
2. Is the pain □ SHARP □ DULL □ ACHING □ OTHER? Is it □ CONSTANT □ INTERMITTENT?
3. Does the pain awaken you at night while sleeping? _____
4. What activities make the shoulder hurt more? _____
5. Does reaching, lifting □ OVERHEAD □ BEHIND YOUR BACK make the pain worse?
6. Do you have □ NUMBNESS □ TINGLING □ A PINS-AND-NEEDLES feeling in your arm or hand?
   Which side(s)? _____

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PAST MEDICAL HISTORY

1. What health problems do you have (check below and add as needed): _____

_____

□ High blood pressure □ Heart Attack/Failure □ Diabetes □ Abnormal Thyroid □ Cholesterol
□ Asthma □ COPD □ Hepatitis B □ Hepatitis C □ Stomach Ulcers □ Bleeding Problems
□ Seizures/Epilepsy □ Stroke □ Sleep Apnea □ Rheumatoid Arthritis
□ Lupus □ Psoriasis □ Cancer _____

2. Have you had ANY OTHER previous surgery? □ Yes □ No If yes, please give details:

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

_____

_____

3. What MEDICINES are you currently taking (name/dose/frequency)? _____

_____

_____

_____

_____

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

_____

5. Do you SMOKE? □ Yes □ No If yes, how many packs per day? □ ½ □ 1 □ ½ □ 2 □ >2
6. Do you use any of the following DRUGS? □ Marijuana □ Cocaine □ Heroin □ Speed □ CBD
7. Do you drink ALCOHOL? □ Yes □ No If yes, how many drinks per day? □ < 1 □ 1 □ 2-3 □ 4-6 □ >6
8. Do you have medical problems in your FAMILY?
   □ High blood pressure □ Heart attack □ Diabetes □ Arthritis □ Bleeding disorder
   □ Cancer □ Premature death □ Epilepsy □ Sickle cell anemia
   □ Other _____
9. Review of systems. (Please check 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