Patient Name:____________________

Wright Orthopaedic Surgery

DOB:________________________

## Shoulder History Form:

Date of Visit: ____ /____ /20____

Which shoulder are we seeing you for? (circle ONLY ONE of the following): *Right/ Left/ Both*

What bothers you the most about your shoulder(s)? (circle ONLY ONE of the following):
*Pain,Swelling, Catching, Locking, Instability(Giving Out), Deformity, Weakness, Grinding, Popping*
*Other:*______________________________________________________________

What else bothers you about your shoulder(s)? (circle ALL of the following that apply to your shoulder(s):
*Pain,Swelling, Catching, Locking, Instability(Giving Out), Deformity, Weakness, Grinding, Popping*
*Other:*______________________________________________________________

When did the shoulder symptoms begin? ______________________________________________

Are symptoms worsening/progressing over time? Yes/No

Was there ever an injury to the shoulder? Yes/No If "Yes", when was the injury? _________
If "Yes", how was it injured? _________

Have you ever had surgery performed on your RIGHTshoulder? Yes/No

If "Yes", what type of surgery(s) and when? (1)________________ (3)________________
(2)________________ (4)________________

Have you ever had surgery performed on your LEFTshoulder? Yes/No

If "Yes", what type of surgery(s) and when? (1)________________ (3)________________
(2)________________ (4)________________

Have you ever had an infection in either shoulder? Yes/No ________________________

Have you ever dislocated either shoulder? Yes/No ________________________

Do you have neck pain? Yes/No ________________________

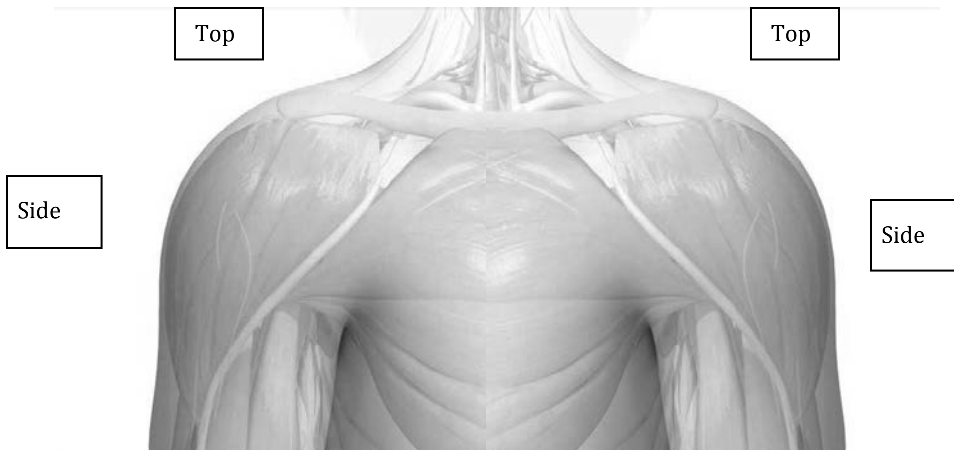
Have you ever had surgery performed on your neck? Yes/No ________________________

Do you ever have numbness or tingling in either arm or hand? Yes/No ________________________

If "Yes", which side and where? ____________________________________

Where is yourshoulderpain located?*(please mark location on the diagrams below with X's, circles, or arrows)*

Right Shoulder: Left Shoulder:




Right Shoulder:

On top In back
On side In front
Deep inside Radiates to neck

Left Shoulder:

On top In back
On side In front
Deep inside Radiates to neck

Is your shoulder pain aggravated by activity that involveslifting the arm? Yes/No

Is your shoulder pain aggravated by activity that involves reaching forward? Yes/No

Is your shoulder pain aggravated by trying to reach behind your back? Yes/No

Is your shoulder pain alleviated by rest (avoiding activity)? Yes/No

Do you have pain in your shoulder at night? Yes/No

If "Yes", does your night pain interfere with sleep? Yes/No

Have you lost strength in your shoulder? Yes/No

What activities aggravate your shoulder? ________________________________________

________________________________________________________________________

What activities have you had to limit or avoid because of your shoulder? ____________________

________________________________________________________________________

Do you feel that your quality of life is suffering because of your shoulder? Yes/No ________

If "Yes", how much is your quality of life suffering?

*(Please circle one of the following):* *Mildly / Moderately / Severely*

Is your quality of life suffering enough for you to consider shoulder surgery? Yes/No ________

# Prior Treatment:

Have you used medication(s) for your shoulder? Yes/No

| Medication Name: | Did it Help? | Are you still taking it? |
|---|---|---|
| (1) ____________________: | Yes/No ________________________: | Yes/No |
| (2) ____________________: | Yes/No ________________________: | Yes/No |
| (3) ____________________: | Yes/No ________________________: | Yes/No |
| (4) ____________________: | Yes/No ________________________: | Yes/No |
| (5) ____________________: | Yes/No ________________________: | Yes/No |

Has your shoulderever been injected with cortisone? Yes/No

How many times? ________ Did cortisone injection(s) help? Yes/No

Have you had physical therapy for your shoulder? Yes/No Did this help? Yes/No

Have you had chiropractic treatment for your shoulder? Yes/No Did this help? Yes/No

What other treatment(s) have you tried? __________________________ Did this help? Yes/No

__________________________ Did this help? Yes/No

__________________________ Did this help? Yes/No

Is there anyother information that you would like to share with us about your shoulder?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

***Thank you very much for completing all of these forms!!***