

Orthopaedic Specialists of Central Arizona

New Patient Medical History – Shoulder

Please help us maintain accurate information on your current and past medical treatment and/or concerns by filling out the following information to the best of your recollection. Thank you!

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Occupation: _____ Retired? Yes No

Primary Care Doctor: _____ Who referred you to our office? _____

What are you being seen for today? _____

Have you seen a doctor for this problem before? No Yes If yes, who? _____

What would you like the doctor to help you with? _____

When did your current problem begin to cause you symptoms? _____

Did a specific injury or accident start your symptoms? No Yes

If Yes, when was the injury/accident? _____ N/A ; Is Injury Work-Related? No Yes

Are you currently involved in an accident or disability litigation/legal action? No Yes

Were x-rays taken? No Yes If yes, where? _____

Are you: Right- or Left- Handed (Please circle)

On a scale of 0 – 10, (0 meaning no pain and 10 meaning the worst pain imaginable) how severe is your pain?

Most of the time: 0 1 2 3 4 5 6 7 8 9 10

When the pain is the worst: 0 1 2 3 4 5 6 7 8 9 10

When the pain is the least: 0 1 2 3 4 5 6 7 8 9 10

Has your pain recently: Worsened Not changed Improved Gone away

Describe the type of symptoms you experience (check all that apply):

Sharp/stabbing Throbbing Shooting Aching Cramping Stiffness

Burning Tingling Numbness

Describe when your pain occurs (check all that apply):

Worse in the morning Worse during the middle of the day Worse at the end of the day

Keeps or wakes me up at night Does not vary significantly during the day

Pain is made worse by (check all that apply):

Sleeping on your side Lifting Reaching above your head Driving Exercise

Pain is made better by (check all that apply):

Resting Lying down Heat Ice Exercise Nothing seems to make the pain better

Name: _____

Have you taken any medicines for your pain?

- Tylenol NSAID's Narcotic pain pills

Have you had any prescribed treatment for your shoulder pain?

- Physical Therapy Injections Other: _____

Do you have any pain below your elbow? Yes No

Do you have any neck pain? Yes No

Please describe any limitations in your activity caused by your pain or other symptoms:

- I have pain if I lift over ____ lbs The pain limits my ability to exercise

- Getting dressed is difficult Combing/brushing my hair is difficult

How often do you exercise? Daily 1-2d/wk 3-4d/wk >5 d/wk

What types of exercise to you usually do? _____

Current prescription medications, including name, dosage, frequency (e.g. Coumadin 1mg, 1x/day)

Over-the-counter medications (including vitamins and supplements):

Please list any medications that you are allergic to, and the reaction you experienced to the medication:

Please list all operations you have had (name and date):

Do you use tobacco now? No Yes If yes, how much and for how long? _____

Have you used tobacco in the past? No Yes If yes, when did you quit? _____

Do you drink alcohol? Never <1/week 1 or 2/day 3+/day

Have you used IV drugs and/or shared needles? No Yes

Do you use a cane, crutches, or a walker? No Yes If yes, please circle which one.

Have you had or now have any infectious diseases such as Hepatitis, Tuberculosis, HIV/AIDS?

No Yes If so, please list: _____ HIV tested? No Yes

What diseases, if any, are common in your family? (i.e. diabetes, heart attacks, cancer, etc.)

Height: _____ Weight: _____

Name: _____

Please indicate any and all medical conditions for which you have been treated:

	Under active treatment	Been treated in the Past
Heart disease	_____	_____
Heart attack	_____	_____
Irregular heart beat	_____	_____
Hypertension (High blood pressure)	_____	_____
Diabetes	_____	_____
Blood clots in your legs	_____	_____
Blood clots in your lungs	_____	_____
Stroke	_____	_____
Osteoporosis (weak bones)	_____	_____
Bleeding problems	_____	_____
Anemia	_____	_____
COPD/Emphysema/Bronchitis	_____	_____
Stomach/Intestinal Ulcer	_____	_____
Gastritis/Reflux disease	_____	_____
Colon/rectal problems	_____	_____
Thyroid disease	_____	_____
Liver disease	_____	_____
Kidney disease	_____	_____
Bladder infection	_____	_____
Prostate difficulty	_____	_____
Severe body aches/Fibromyalgia	_____	_____
MRSA infection	_____	_____
Dental infections or loose teeth	_____	_____
Hepatitis	_____	_____
Tuberculosis	_____	_____
HIV/AIDS	_____	_____
Significant weight loss or gain	_____	_____

By signing below, I certify that I have understood the questions and have answered honestly and to the best of my knowledge.

Signature: _____ Date: _____

*We, at Orthopaedic Specialists of Central Arizona, assure you that the above information is part of your personal and private medical record. As such, it will not be shared with anyone outside this office without your specific, written permission, except for circumstances wherein we are required to do so by law.

Thank you for your time and cooperation!