THE SHOULDER CLINIC
OF IDAHO P.L.L.C.

SHOULDER INFORMATION SHEET

Patient Name:
_____

Height:_____ **Weight:**_____

Date Form Completed: _____

Referred By:
_____

Dominant Hand: ☐ Left ☐ Right
☐ Ambidextrous

Affected Shoulder: ☐ Left ☐ Right

Did the symptoms start slowly or suddenly:
☐ Slowly ☐ Suddenly

When did your symptoms start?
_____

On a scale of 1-10, indicate your pain level:
1 2 3 4 5 6 7 8 9 10

Have you had a recent injury, fall or other accident: ☐ Yes ☐ No
If Yes Explain:
_____
_____

Briefly describe your shoulder problem:
_____
_____
_____
_____

Symptoms (Check All Appropriate):
☐ Pain ☐ Stiffness ☐ Weakness
☐ Instability ☐ Roughness

Pain is experienced (Check All Appropriate):
☐ at rest ☐ with activity ☐ at night
☐ while raising arm or reaching

Does the pain travel from your shoulder to other parts of your body?
If yes, where?
_____

Does anything make your pain:
Better: _____
Worse: _____

Previous treatment has included (Check All Appropriate):
☐ Physical Therapy - If yes, how long?
_____
☐ Injections – If yes, when was your last injection?
_____ ☐ Medications
☐ Activity Modifications ☐ Acupuncture
☐ Chiropractic ☐ Surgery ☐ None of the above

Previous Shoulder Imaging (Check All Appropriate): ☐ MRI ☐ EMG ☐ Bone Scan
☐ CT Scan ☐ X-Ray

Occupation:_____
Position:_____
☐ Heavy Manual Labor ☐ Light Manual Labor
☐ Sedentary Work

Usual Activities/Sports Include:
_____
_____
_____

MEDICAL DATA SHEET

Patient Name_____**Date:**_____

Height: _____ **Weight:**_____

Past Medical History List current or previous medical conditions. Examples include high blood pressure, heart attack, diabetes, cancer, thyroid, depression, blood clots, etc

Condition	Doctor

Primary Care Provider: _____

Past Surgical History

Surgery	Year	Doctor/Location

Current Medications

Medication Name	Strength	How many pills at a time	Times per day

Allergies/Reactions to Medications, Latex, Sutures, Metal, Etc.

Allergy	Reaction

Social History

Smoking:	Never	Former (year quit_____)		Current (packs/day_____)
Alcohol:	Never	Rarely	Occasionally	Daily

Family History

Cancer	Heart Disease	Arthritis	Reaction to Anesthesia	Abnormal Bleeding/Clotting
Explain: _____				
_____				
_____				

Is there any chance you could be pregnant? _____

Advance Care Plan: Do you have a Living Will or Medical Power of Attorney? _____

Review of Systems (Please circle all symptoms that you *currently* experience/ new or different from your chronic complaints)

General	Fevers	Weight Changes	Abnormal Sweats	Fatigue	Dizziness
Skin	Rash	Infections	Bruise Easily	Itching	Skin Growths
Eyes/Ears/Nose/Throat	Vision Loss	Blurred Vision	Hearing Loss		
Nose/Throat	Dentures	Difficulty Swallowing			
Respiratory	Cough	Shortness of Breath	Wheezing		
Cardiovascular	Chest Pain	Irregular Heartbeat	Lower Leg Swelling		
Endocrine	Sweating	Excessive Thirst	Excessive Urination		
Gastrointestinal	Bloody Stools Nausea	Constipation Vomiting	Diarrhea Abdominal Pain		
Urinary	Incontinence	Urgency	Frequency	Hesitancy	
Neurological	Frequent Headaches	Numbness	Tingling	Weakness	
Musculoskeletal	Fractures	Joint Pain	Joint Swelling	Muscle Aches	
Emotional	Anxiety	Depression	Bipolar	ADHD	