Jacob D. Rozbruch, M.D.
Orthopaedic Surgery

PATIENT SHOULDER QUESTIONNAIRE

Name _____ Age _____
Date _____ Chart # _____ Sex ☐ Male ☐ Female

BP _____/_____ Pulse _____
Temp _____ Resp _____

Problem with: ☐ Right ☐ Left ☐ Both Which is worse: ☐ Right ☐ Left
I am: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Work History

Occupation: _____ Is the problem work related? ☐ Yes, Date: _____ ☐ No
Are you presently working?
☐ Yes If yes, are you presently on modified duty? ☐ Yes ☐ No
☐ No Unemployed, since _____ Off work, since _____ Last day worked? _____
If you are not working, is it due to your shoulder problem? ☐ Yes ☐ No
OR is it because you are: ☐ Retired ☐ A student ☐ A homemaker ☐ Disabled ☐ Other
Is this problem related to a motor vehicle accident? ☐ Yes, Date: _____ ☐ No
Is there an attorney involved with your worker compensation or auto accident claim? ☐ Yes ☐ No
Attorney's name: _____

I am having problems with: (Mark all that apply)

☐ Pain at rest
☐ Stiffness (Loss of motion)
☐ Catching / Locking
☐ Swelling
☐ Pain with use of arm
☐ Weakness
☐ Loss of work
☐ Instability (Shoulder pops out)
☐ Grinding / Popping
☐ Loss of activity / sport

Other problems that apply:

☐ Neck ☐ Back ☐ Arthritis ☐ Nerve Problems ☐ Heart ☐ Lung ☐ Circulation ☐ Other
Do you have:
☐ Neck Pain ☐ Trigger Points ☐ Upper Back Pain ☐ Trapezius Pain ☐ Radiation of Pain
Where does pain radiate? _____
The problem is getting: ☐ Better ☐ Worse ☐ No Better, No Worse

Onset of the problem:

☐ Gradually, since _____ Describe: _____
_____
☐ Suddenly but without injury, on _____ Describe: _____
_____
☐ Injury, on _____ Occured while: ☐ Throwing ☐ Lifting ☐ Falling ☐ Skiing ☐ Snowboarding
☐ Other sport _____ ☐ Other _____
Describe injury: _____

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Prior treatment for this problem:

☐ Yes ☐ No If yes, treated by: ☐ ER ☐ Family MD ☐ Orthopedic MD ☐ PT ☐ Chiropractor ☐ Self

If previously treated, what was the diagnosis? _____

Physician's name: _____

TYPE OF PRIOR TREATMENT	HOW OFTEN?	OVER HOW LONG?	HELP	HURT	NO EFFECT	COMMENTS?
Physical Therapy			☐	☐	☐	
Anti-inflammatories			☐	☐	☐	☐ Advil ☐ Aleve ☐ Rx
Cortisone Injections			☐	☐	☐	How many total?:
Rest			☐	☐	☐	
Chiropractic			☐	☐	☐	
Massage Therapy			☐	☐	☐	
Acupuncture			☐	☐	☐	

Have you had other problems with your shoulders in the past? ☐ Yes ☐ No If yes, please describe: _____

_____

Previous shoulder surgery: ☐ Yes ☐ No If yes, please complete lines below for each surgery:

Month/Day/Year Doctor's Name: Type: Results:

1) _____ _____ _____ _____

2) _____ _____ _____ _____

Previous X-Rays: ☐ Yes ☐ No If yes, please list the date, location and results below (if you know):

Month/Day/Year Location (Hospital/ER/Office/Doctor/City) Results:

1) _____ _____ _____

2) _____ _____ _____

Previous MRI / Arthrogram / Ultrasound / CAT Scan: ☐ Yes ☐ No If yes, please list below (if you know):

Month/Day/Year Location (Hospital/ER/Office/Doctor/City) Type (MRI, etc): Results:

1) _____ _____ _____ _____

2) _____ _____ _____ _____

PAIN:

If you are not experiencing pain, skip this section.

Quality of Pain:

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

Location of Pain:

☐ Front ☐ Side ☐ Back ☐ Arm pit ☐ Top side ☐ Deep inside

☐ Forearm ☐ Hand ☐ AC Joint ☐ Cannot locate exact spot ☐ Other _____

Frequency of Pain:

☐ Rarely ☐ Occasionally ☐ Frequently ☐ Constantly

Time of day when pain occurs:

☐ Morning ☐ Day ☐ End of day ☐ Night ☐ Interrupts sleep ☐ Weather change

Pain made worse when:

☐ Resting ☐ Any shoulder motion ☐ Lifting only arm itself ☐ Lifting any weight
☐ Throwing ☐ Physical therapy ☐ Sleeping on shoulder ☐ Working overhead
☐ Driving ☐ Reaching away from body ☐ Reaching behind you ☐ You work
☐ Weight Lifting: ☐ Bench Press ☐ Military ☐ Flys ☐ Other _____

Pain relieved by:

☐ Nothing ☐ Rest ☐ Activity ☐ Physical Therapy ☐ Moving the shoulder
☐ Injections ☐ Ice ☐ Heat ☐ Other _____

Night pain:

☐ If you sleep on shoulder ☐ Causes you to toss & turn ☐ Wakes you from sleep ☐ Prevents sleep
☐ Causes you to get up ☐ Less if sitting up (recliner) ☐ Requires medicine

Pain Medications:	During the day		At Night	
Anti-inflammatories:	☐ Occasionally	☐ Frequently	☐ Occasionally	☐ Frequently
Vicodin or Percocet:	☐ Occasionally	☐ Frequently	☐ Occasionally	☐ Frequently

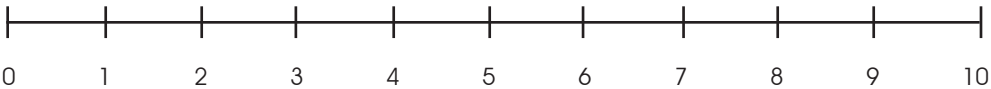
Preferred sleeping position:

☐ Back ☐ Stomach ☐ Side, problem side down ☐ Side, problem side up
☐ Arm over head -- Does your shoulder allow you to sleep in this position? ☐ Yes ☐ No

ACTIVITIES:
Circle the number in the box that indicates your ability to do the following activities:
0 = unable to do; 1 = very difficult to do; 2 = somewhat difficult; 3 = not difficult.

ACTIVITY	RIGHT ARM	LEFT ARM
Put on coat	0 1 2 3	0 1 2 3
Sleep on your painful or affected side	0 1 2 3	0 1 2 3
Wash back / do up bra in back	0 1 2 3	0 1 2 3
Managing toileting	0 1 2 3	0 1 2 3
Comb hair	0 1 2 3	0 1 2 3
Reach a high shelf	0 1 2 3	0 1 2 3
Lift 10lb. above your shoulder	0 1 2 3	0 1 2 3
Throw a ball overhand	0 1 2 3	0 1 2 3
Do your usual work	0 1 2 3	0 1 2 3
Do usual sport. What is your usual sport?:	0 1 2 3	0 1 2 3

How bad is your pain today? (MARK LINE)



0 1 2 3 4 5 6 7 8 9 10

NO PAIN SEVERE PAIN

INSTABILITY
If your shoulder does not "go out of place", skip this section.

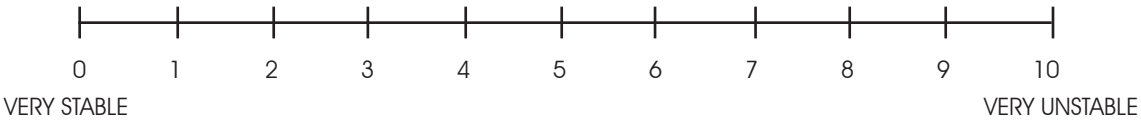
My shoulder goes out:

☐ At the time of the original injury ☐ Regularly ☐ With major injury or stress
☐ With simple movements ☐ Partially then goes back in ☐ Never but feels like it might

Complete dislocations occur how often? _____ Total number of dislocations: _____
Date of first dislocation: _____ Date of last dislocation: _____

Does your shoulder hurt when its not out of place? ☐ No ☐ Occasionally ☐ Frequently ☐ Mild ☐ Moderate
Are you able to intentionally slip your shoulder out of place? ☐ Yes ☐ No
Have you required help to put shoulder back in? ☐ Yes ☐ No Explain: _____
Have you been able to put the shoulder back in by yourself? ☐ Yes ☐ No Explain: _____
The shoulder goes back in: ☐ Easily ☐ With moderate difficulty ☐ With great difficulty
Describe shoulder position when it goes out: _____
Where does the shoulder go out? ☐ Front ☐ Back ☐ Armpit ☐ Not sure

How unstable is your shoulder? (MARK LINE)



PLEASE SIGN
This information is accurate to the best of my knowledge.

Patient Signature: _____

FOR OFFICE USE ONLY: Complete _____ Date ____/____/____

Review #1: _____ MD Date ____/____/____ Review #2: _____ MD Date ____/____/____