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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)

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain at rest | <input type="checkbox"/> Pain with use of arm | <input type="checkbox"/> Instability (Shoulder pops out) |
| <input type="checkbox"/> Stiffness (Loss of motion) | <input type="checkbox"/> Weakness | <input type="checkbox"/> Grinding / Popping |
| <input type="checkbox"/> Catching / Locking | <input type="checkbox"/> Loss of work | <input type="checkbox"/> Loss of activity / sport |
| <input type="checkbox"/> Swelling | | |

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: _____

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			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anti-inflammatories			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Advil <input type="checkbox"/> Aleve <input type="checkbox"/> Rx
Cortisone Injections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many total?:
Rest			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chiropractic			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Massage Therapy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Acupuncture			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

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: _____

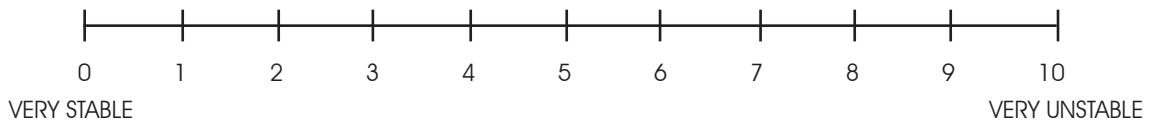
Have you been able to put the shoulder back in by yourself? Yes No Explain: _____

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 ____/____/____	Date ____/____/____