

# MEDICAL HISTORY FORM – SHOULDER

## DEMOGRAPHIC INFORMATION

NAME: \_\_\_\_\_ FMP/Sponsor SSN: \_\_\_\_ / \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_ AGE \_\_\_\_\_ DOD ID Number: \_\_\_\_\_  
 HOME PHONE NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ WORK PHONE NUMBER: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 EMAIL ADDRESS: \_\_\_\_\_ MAY WE CONTACT YOU BY EMAIL: YES NO  
 DUTY STATION/EMPLOYER: \_\_\_\_\_  
 RANK/OCCUPATION: \_\_\_\_\_

## PATIENT HISTORY

WHICH SHOULDER BOTHERS YOU? RIGHT LEFT BOTH DOMINANT HAND: RIGHT LEFT  
 How would you rate your shoulder today as a percentage of normal (0% to 100% scale with 100% being normal)? \_\_\_\_\_  
 What is your chief complaint? \_\_\_\_\_ DATE OF ONSET: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 NO INJURY: (please circle type of onset) GRADUAL SUDDEN  
 Please indicate why you think it started: \_\_\_\_\_  
 \_\_\_\_\_  
 INJURY: (please circle) ACCIDENT SPORT (type) \_\_\_\_\_ WORK SCHOOL OTHER \_\_\_\_\_  
 Please specify where and how it happened: \_\_\_\_\_  
 \_\_\_\_\_  
 Have you had a problem like this before? Yes No \_\_\_\_\_  
 Are your symptoms: Getting Better Unchanged Getting Worse

WHAT SYMPTOMS DO YOU HAVE				CAN YOU? (Check if yes)				
RIGHT			LEFT		RIGHT		LEFT	
<input type="checkbox"/>	Night Pain	<input type="checkbox"/>	<input type="checkbox"/>	Night Pain	<input type="checkbox"/>	Throw	<input type="checkbox"/>	Throw
<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	Use your arm overhead	<input type="checkbox"/>	Use your arm overhead
<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	Work	<input type="checkbox"/>	Work
<input type="checkbox"/>	Feels Unstable	<input type="checkbox"/>	<input type="checkbox"/>	Feels Unstable	<input type="checkbox"/>	Play sports	<input type="checkbox"/>	Play sports
<input type="checkbox"/>	Limited Motion/ Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Limited Motion/ Stiffness	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>		<input type="checkbox"/>	

IF YOU HAVE INSTABILITY, WHAT ACTIVITIES CAUSE IT? \_\_\_\_\_  
 IF YOU HAVE PAIN, WHERE IS IT LOCATED? \_\_\_\_\_  
 How would you rate your pain on a scale of 0 to 100, with 0 being no pain and 100 being the worst possible pain? \_\_\_\_\_  
 WHAT IS THE QUALITY OF THE PAIN? Sharp Dull Stabbing Throbbing Aching Burning  
 ACTIVITY-RELATED SYMPTOMS:  
 Is your shoulder comfortable at rest? YES NO  
 Can you perform your normal activities of daily living? YES NO  
 Can you participate in your desired sporting activities? YES NO

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WHAT MAKES YOUR SYMPTOMS WORSE? \_\_\_\_\_  
 WHAT MAKES YOUR SYMPTOMS BETTER? \_\_\_\_\_  
 HAVE YOU HAD A PREVIOUS INJECTION? YES NO IF YES WHEN? \_\_\_\_\_  
 HAVE YOU HAD ANY PHYSICAL THERAPY? YES NO IF YES WHAT TYPE \_\_\_\_\_  
 WHAT TESTS/SCANS HAVE YOU HAD FOR THIS PROBLEM? X-Rays MRI CT Scan Nerve Test  
 HAVE YOU ALREADY HAD SURGERY FOR A PROBLEM IN THE SAME AREA IN THE PAST? YES NO  
 If yes, please list below:  
 Procedure #1 \_\_\_\_\_ Date \_\_\_\_\_ Surgeon \_\_\_\_\_  
 Procedure #2 \_\_\_\_\_ Date \_\_\_\_\_ Surgeon \_\_\_\_\_

**PAST MEDICAL HISTORY:** Do you have or have you ever had:  
 Heart Attack (year \_\_\_\_\_) High Blood Pressure Blood Clots (year \_\_\_\_\_)  
 Stroke Heart Failure Ankle Swelling  
 Kidney Failure Cancer (type \_\_\_\_\_) Diabetes  
 Stomachache while taking anti-inflammatory medications (which type \_\_\_\_\_)  
 MRSA Infections  
 Any other medical conditions (please list): \_\_\_\_\_

**PAST SURGICAL HISTORY:** What operations have you had and when? Please list:  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE LIST ALL CURRENT MEDICATIONS:**

NAME	DOSAGE	FREQUENCY

**ALLERGIES TO ANY MEDICATIONS**

PENICILLIN YES NO Reaction: \_\_\_\_\_  
 SULFA DRUGS YES NO Reaction: \_\_\_\_\_  
 NOVOCAINE YES NO Reaction: \_\_\_\_\_  
 OPIATES (VICODIN/PERCOCET) YES NO Reaction: \_\_\_\_\_  
 CORTISONE YES NO Reaction: \_\_\_\_\_  
 FOODS YES NO Reaction: \_\_\_\_\_  
 OTHER YES NO Reaction: \_\_\_\_\_

**LATEX ALLERGY SCREENING:** Have you ever had a reaction including swelling, itching or difficulty breathing when exposed to latex, rubber materials like gloves, condoms, balloons or foods such as bananas, avocados, papayas, or kiwi fruit? YES NO Reaction: \_\_\_\_\_

Have you or a family member every had a reaction to anesthesia? YES NO  
 If yes, EXPLAIN: \_\_\_\_\_

**FAMILY HISTORY:** Have any direct relatives had any of the following? If so, which relative?

Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Heart Disease \_\_\_\_\_  
Rheumatoid Arthritis \_\_\_\_\_ Cancer \_\_\_\_\_ Nerve Disorder \_\_\_\_\_  
Bleeding disorders \_\_\_\_\_ Clotting disorders \_\_\_\_\_

**SOCIAL HISTORY:**

Do you use tobacco? YES NO If yes, packs per day \_\_\_\_\_ / cans per day \_\_\_\_\_ / other \_\_\_\_\_  
Do you use alcohol? YES NO If yes, how often? \_\_\_\_\_ drinks per DAY/WEEK  
Chemical Dependency? YES NO If yes, please specify \_\_\_\_\_

**MILITARY AND DUTY STATUS (ACTIVE DUTY ONLY):**

WHAT IS YOUR PROJECTED ROTATION DATE OR END OF OBLIGATED SERVICE: PRD/EOS \_\_\_\_\_  
YEARS OF ACTIVE SERVICE: \_\_\_\_\_  
ARE YOU ON FLIGHT OR DIVE STATUS? YES NO IF YES WHICH? \_\_\_\_\_  
ARE YOU CURRENTLY ON LIGHT DUTY? YES NO IF YES: FOR HOW LONG? \_\_\_\_\_  
ARE YOU CURRENTLY ON LIMDU? YES NO IF YES: WHAT PERIOD OF LIMDU? 1 2 OTHER \_\_\_\_\_  
HAVE YOU PREVIOUSLY BEEN ON LIMDU? YES NO IF YES: HOW MANY PERIODS? 1 2 OTHER \_\_\_\_  
ARE YOU CURRENTLY ON A MEDICAL BOARD (PEB)? YES NO

**REVIEW OF SYSTEMS:** Have you had any of these symptoms? If NO, mark NONE

GI	Heartburn, Ulcers	Nausea, Vomiting	Hepatitis or Liver disease	NONE	
ENDO	Thyroid Disease	Heat or Cold Intolerance		NONE	
CON	Weight Loss	Loss of Appetite		NONE	
EYE	Blurry Vision	Double Vision	Loss of Vision	NONE	
ENT	Hearing Loss	Hoarseness	Difficulty Swallowing	NONE	
CV	Hypertension	Palpitations	Pacemaker	Heart Disease/Failure	NONE
RESP	Chronic Cough	Shortness of Breath	Asthma	COPD Sleep Apnea	NONE
GU	Painful Urination	Blood in Urine	Kidney Problems		NONE
SKIN	Frequent Rashes	Skin Ulcers	Lumps	Psoriasis	NONE
NEURO	Frequent Headaches	Dizziness	Seizures		NONE
HEME	Easy Bleeding	Easy Bruising	Anemia	Blood Clots	NONE

Women: Are you pregnant? YES NO Delivery Date: \_\_\_\_\_

**ARE THERE ANY SPECIFIC QUESTIONS YOU WOULD LIKE TO DISCUSS TODAY?**

\_\_\_\_\_

## SHOULDER EXAM

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Height		Weight							
RIGHT					LEFT				
C-Spine	WNL	DEC ROM	Pain	Spurling	WNL	DEC ROM	Pain	Spurling	
SC Joint	WNL	TENDER			WNL	TENDER			
Scapulo thoracic	WNL	CREPITUS	WINGING		WNL	CREPITUS	WINGING		
Flexion		Deg				Deg			
Abduction		Deg				Deg			
ER At Neutral		Deg				Deg			
IR At Neutral		Deg				Deg			
ABER		Deg				Deg			
ABIR		Deg				Deg			
ANT INSTABILITY Apprehension Relocation	Positive Positive	Negative Negative			Positive Positive	Negative Negative			
POST INSTABILITY Kim Jerk	Positive Positive	Negative Negative			Positive Positive	Negative Negative			
LOAD AND SHIFT Anterior Posterior Inferior/Sulcus	Positive Positive Positive	Negative Negative Negative			Positive Positive Positive	Negative Negative Negative			
IMPINGEMENT Neer Hawkins	Positive Positive	Negative Negative			Positive Positive	Negative Negative			
ROTATOR CUFF Supraspinatus External Rotation Subscapularis		/5 /5 /5				/5 /5 /5			
AC JOINT TTP Cross Arm Adduct.	Positive Positive	Negative Negative			Positive Positive	Negative Negative			
SLAP O'Brien Speeds Yergason's	Positive Positive Positive	Negative Negative Negative			Positive Positive Positive	Negative Negative Negative			
LHB Tenderness	Positive	Negative			Positive	Negative			

**XRAYS:**

**MRI:**

**IMPRESSION:**

**PLAN:**

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