

Questionnaire for New Patients – Shoulder Injury

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- (1) Please return this completed form to our office **BEFORE** your appointment either by fax or mail. (2) Please bring any prior **MRI** films, x-rays, or medical records to the office with you for your appointment. (3) Please bring a sleeveless shirt or tank top. Thank you.

Your Name: _____ Date: _____

Who is your primary care physician? _____

When did you last see him / her? _____

Past Medical History: Please check the appropriate boxes:

Have you ever had any of the following (**in the past**)?

- | | |
|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent bloody noses or bleeding gums |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Bladder or Urinary Infections | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Cancer (type: _____) | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Cramping in leg while walking | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Deep Venous Thrombosis | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recurrent infections |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Slowly healing wounds |
| | <input type="checkbox"/> Stomach ulcer |

Review of Systems:

Do you **currently** have any of the following?

- Reaction of NSAID/anti-inflammatory medications (Advil, ibuprofen, Naproxen, Indocin, Celebrex, etc.)
- Fever, chills
- Recent weight gain, recent weight loss
- Changes in vision, sensitivity to light, blurred vision, double vision
- Change in hearing, bloody noses, sore throat, cough
- Shortness of breath, chest pain, wheezing, coughing of blood
- Palpitations, light headedness, dizziness
- Loss of appetite, weight loss, pain with swallowing, nausea, vomiting, abdominal pain or bloating, blood in your stools, diarrhea, constipation
- Difficulty urinating, pain with urination, blood in your urine
- Rashes, insect bites, new skin lesions

What Medications do you take?

1. _____
2. _____
3. _____
4. _____

Are you allergic to any medications?

- Yes: _____
- No

Do you smoke?

Yes (packs per day _____)

- No

How much alcohol do you drink? _____

What surgeries have you had in the past?

1. _____
2. _____
3. _____
4. _____

Shoulder History:

- Right
- Left

When did your shoulder problem begin? _____

How did it start?

- Sports Injury
- Work Injury
- Overuse (running, cycling, swimming)
- Work Overuse
- Gradually
- Spontaneously (for no apparent reason)

What treatment have you had for this shoulder injury?

- Medications
- Physical therapy
- Cortisone Injection
- Surgery

Have you had any of the following for this shoulder injury (Please bring the films to the office with you!):

- X-ray
- MRI
- CT scan

Have you had this problem before?

- Yes
- No

What part of your shoulder hurts?

- Front
- Outer side (deltoid region)
- Back
- Upper
- Shoulder Blade
- Base of neck / trapezius region

What makes the pain worse?

- Prolonged use
- Reaching or using over head
- Throwing or hitting a tennis serve
- Lifting weights (which exercises? _____)
- Pulling on object off a shelf (example: gallon of milk out of refrigerator)
- Pulling an object up from the floor (suitcase, etc)
- Tucking in a shirt

Does the pain wake you up from sleep?

- Yes
- No

If the pain is worse when you throw /serve, which part of the throw hurts the most?

- Cocking
- Ball release (or striking the tennis ball)
- Finishing the throw / follow through

Do you have any of the following?

- Painful popping
- Sensation of catching (something getting caught / pinched between the bones)
- Coming out of joint
- Dead arm
- Pain radiating down arm (if so, where does it go _____)
- Numbness in arm
- Swelling or discoloration of arm after throwing
- None of the above

Has the shoulder ever come out of joint:

- Part way (Subluxation, the bones feel like they slip out of place)
- All the way (Dislocation)
- None of the above

Describe your job's physical demands:

- Manual Labor: including lifting, carrying, pulling, pushing, working with arms over head (eg, mechanic, construction, laborer, etc)
- Moderate: regular use of arms but not heavy.
- Office environment
- Student
- Other

Are you working at your usual job

- Yes
- No, light duty
- No, off work due to injury
- No, off work for other reasons

What were your typical most strenuous recreational activities before your shoulder problem began:

- High intensity sports (football, baseball, basketball, tennis, racquetball, etc)
- Moderate intensity sports (recreational skiing, running, cycling, etc)
- Low intensity sports (walking, golf, etc)
- Activities of Daily living

What are your most strenuous recreational activities since your shoulder problem began:

- High intensity sports (football, baseball, basketball, tennis, racquetball, etc)
- Moderate intensity sports (recreational skiing, running, cycling, etc)
- Low intensity sports (walking, golf, etc)
- Activities of daily living

What type of activities do you intend to return to after your shoulder problem resolves?

- High intensity sports (football, baseball, basketball, tennis, racquetball, etc)
- Moderate intensity sports (recreational skiing, running, cycling, etc)
- Low intensity sports (walking, golf, etc)
- Manual Labor
- Desk Job
- Activities of daily living

Do you lift weights for exercise/recreation? If so, how many times per week?

- Less than two times per week
- Two – three times per week
- More than three times per week
- Bodybuilder
- Don't lift weights

Have you had an MRI of this shoulder since this problem began?

If so, what did the MRI show _____

What prior injuries have you had to this shoulder?

- None
- Cartilage / Labral tear
- Dislocation
- Subluxation
- Sprain / strain
- Rotator Cuff Tear
 - Partial
 - Complete
- Separation
- Impingement

What Surgeries have you had on this shoulder?

- None
- Arthroscopy (year: _____)
- Labral repair (year: _____)
- Tightening of shoulder (year: _____)
 - Open
 - Arthroscopic

- Bankart repair / reconstruction (year: _____)
 - Open
 - Arthroscopic
- Debridement / cleaning out (year: _____)
- Rotator Cuff Repair (year: _____)
 - Open
 - Arthroscopic
- Removal of outer portion of clavicle (year: _____)

What are your goals for today's visit:

- Gain information about condition
- Make sure you are not damaging shoulder
- Fix the problem as long as it does not involve surgery
- Fix the problem even if it requires surgery

Patient Signature _____

Parent/Guardian Signature (if patient is a minor) _____

Thank you,

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