OrthoConnecticut
World-class care, close to home.

DR. BRAND
SHOULDER MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____ Date: _____

Orthopedic History: _____ Reason for Visit: _____

Is this problem a result of: ❑ MVA ❑ Liability ❑ Work Related ❑ Trauma

Date of Injury: ____/____/____ Description of Injury: _____

Side: ❑ Right ❑ Left Dominant: ❑ Right-Handed ❑ Left-Handed

History of Present Injury or Complaint: _____

How long have you had shoulder pain? _____

Do you have pain in your shoulder at night? ❑ Yes ❑ No

Do you take any medications for your shoulder? ❑ Yes ❑ No

What medications do you take for your shoulder? _____

Does your shoulder feel unstable (as if it's going to dislocate)? ❑ Yes ❑ No

Do you have pain with daily activities? ❑ Yes ❑ No

Does it hurt to lift your arm above your head? ❑ Yes ❑ No

Do you have pain while throwing? ❑ Yes ❑ No

Have you ever had an injury to your shoulder? ❑ Yes ❑ No

Do you have any numbness or tingling? ❑ Yes ❑ No Where: _____

Do you now have or have you ever had:

CONSTITUTIONAL:

Recent weight changes	❑ Yes	❑ No				
Recent fever, weakness or fatigue	❑ Yes	❑ No				

EYES:

Wear glasses or contact lenses	❑ Yes	❑ No				
Glaucoma	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Cataracts	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:

EARS, NOSE, THROAT:

Hearing Problems	❑ Yes	❑ No				
Dizziness	❑ Yes	❑ No				
Recent cold or sinus pain	❑ Yes	❑ No				
Recent sore throat	❑ Yes	❑ No				

CARDIOVASCULAR:

Chest pain	❑ Yes	❑ No				
Heart attack	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Stroke	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Heart failure	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
High blood presure	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Irregular heartbeat	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
Swelling of hands or feet	❑ Yes	❑ No				
Blood clots	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:
High cholesterol	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:

RESPIRATORY:

Asthma ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____
Emphysema ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____
Bronchitis ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____
Pneumonia ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

GASTROINTESTINAL:

Recent changes in bowel habits ❑ Yes ❑ No
Rectal bleeding ❑ Yes ❑ No
Liver disease ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

URINARY:

Problems with urination ❑ Yes ❑ No
Urinary tract infections ❑ Yes ❑ No
Kidney disease ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

SKIN:

Recent or current rashes or eruptions ❑ Yes ❑ No Where: _____

NEUROLOGICAL:

Seizures ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____
Paralysis ❑ Yes ❑ No Where: _____
Numbness or tingling ❑ Yes ❑ No Where: _____
Depression/mental illness ❑ Yes ❑ No When: _____
Anxiety disorders ❑ Yes ❑ No When: _____

ENDOCRINE:

Thyroid ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____
Diabetes ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____
Treatment: ❑ Diet ❑ Oral Meds ❑ Insulin
Medical complications: ❑ Vascular ❑ Renal ❑ Neuropathy ❑ Other: _____

HEMATOLOGIC/LYMPHATIC:

Anemia ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____
Transfusions ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____

CANCER/TUMOR: ❑ Yes ❑ No Family History ❑ Yes ❑ No Member: _____
Type: _____ Location: _____ Treatment: _____

OTHER MEDICAL PROBLEMS: _____

_____

_____

HISTORY OF OPERATIONS: ❑ Yes ❑ No
Type: _____

_____

_____

DO YOU HAVE ALLERGIES, SENSITIVITIES OR HAVE YOU AN ADVERSE REACTION TO MEDICATIONS? ❑ Yes ❑ No
Please List: _____

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CURRENT MEDICATIONS: _____

When did you last use aspirin in any form? _____

PERSONAL HISTORY:

Cigarettes ❑ Yes ❑ No Amount: _____

Alcohol ❑ Yes ❑ No Amount: _____

OCCUPATION: _____

TESTS DONE RELATED TO PRESENT INJURY OR COMPLAINT:

❑ X-rays ❑ MRI ❑ CT Scan ❑ EMG ❑ Bone Scan ❑ Bone Density ❑ Bloodwork

Tests performed at: _____

PRIOR TREATMENT (Best recollection – Check and explain):

❑ Anti-Inflammatories:

❑ Injections (dates & number):

❑ Chiropractic:

❑ Surgery:

Physical Therapy:
❑ Ulttrasound ❑ Massage ❑ Strengthening ❑ ROM Stretching
❑ Cybex Machines ❑ Cryotherapy ❑ Cortisone Cream ❑ Manipulation
❑ Electrical Stimulation

YOUR MEDICAL DOCTOR:
Name: _____
Address: _____
Phone: _____

YOUR REFERRING DOCTOR:
Name: _____
Address: _____
Phone: _____

PATIENT SIGNATURE: _____

MD SIGNATURE/DATE: _____

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SHOULDER PHYSICAL EXAM

TO BE FILLED OUT BY THE PHYSICIAN

CERVICAL ROM	❑ Flexion ❑ Extension ❑ Lateral bending ❑ Lateral rotation
GENERAL	❑ Deformity ❑ Contusion ❑ Atrophy
TENDERNESS	❑ Anterior ❑ Posterior ❑ Lateral
RANGE OF MOTION	❑ Forward elevation ❑ Internal rotation ❑ External rotation
STRENGTH	❑ Supraspinatus ❑ Deltoid
INSTABILITY	❑ Anterior apprehension ❑ Posterior apprehension ❑ Inferior apprehension
ROTATOR CUFF	❑ Impingement sign ❑ Hawkin's sign ❑ Yergason test
SLAP	❑ O'Brien's test
AC JOINT	❑ Adduction stress test
SEAPULA	❑ Scapulothoracic crepitus
NEURO EXAM	❑ C5-T1
WRIST/ELBOW	