New Shoulder Patient Questionnaire

Patient Name: ____________________  Account #: ___________

From the list below, please circle the main problem you are having with your shoulder?

- Pain
- Weakness
- Painful Popping
- Loss of Function
- Difficulty Sleeping
- Difficulty with Sports Activities

Is there a specific injury that is responsible for this problem?

YES   NO

If yes, please list the injury.

Has anything like this ever happened before to your shoulder?

YES   NO

Have you ever dislocated either shoulder before?

YES   NO

Do you have numbness or tingling associated with this shoulder problem?

YES   NO
Is there neck pain associated with this shoulder problem?

**YES**  **NO**

Does moving your neck make the shoulder / arm pain worse?

**YES**  **NO**

Have you had any injections for this?

**YES**  **NO**

Have you had any therapy for this?

**YES**  **NO**

Have you had any surgery for this?

**YES**  **NO**

Which sports or athletic activity do you enjoy?

**For those patients who have had previous surgery:**

How many times have you gone to the operating room total for this shoulder?

List procedures, surgeons and approximate dates:

Has there ever been an infection in your shoulder?

**YES**  **NO**

Do you have the operative reports from the previous surgery?

**YES**  **NO**

If not, can you obtain your records from your doctor?

**YES**  **NO**