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?

<u>For those patients who have had previous surgery:</u>

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**