SIDELINE ORTHOPEDICS AND SPORTS MEDICINE

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New Patient Medical History for SHOULDER Symptoms

Name:_____ Today's Date: _____

Age:_____ Phone number: _____

Referred by:_____ Date of Injury/Onset of symptoms: _____

Reason for visit. Describe injury or onset in detail: ❑ LEFT ❑ RIGHT _____

_____

_____

_____

Pain: ❑ Sharp ❑ Dull ❑ Stabbing ❑ Burning ❑ Other: _____

❑ Constant ❑ Intermittent **Intensity:** 0—1—2—3—4—5—6—7—8—9—10

Location (describe): _____

Does the pain go anywhere else (describe)? _____

What makes pain worse? ❑ Pushing ❑ Pulling ❑ Reaching Overhead ❑ Across body ❑ Behind back

❑ Sleeping ❑ Driving ❑ Throwing ❑ Lifting Weights ❑ Other: _____

What makes pain better? ❑ Rest ❑ Activity Modification ❑ Ice/Heat ❑ Meds

❑ Other: _____

What other symptoms are present? ❑ Catching ❑ Popping ❑ Grinding ❑ Locking

❑ Dislocation ❑ Subluxation ❑ Swelling (❑ constant ❑ fluctuates)

What treatments have you attempted and what effect? (PT, meds, injections) _____

_____

Can you work or participate in sports with current symptom? ❑ NO ❑ YES

Do you have light duty available at work? ❑ NO ❑ YES

Past Medical and Family History (check all that apply ❑ **You** ❑ **Family History**)

❑ ❑ High Blood Pressure	❑ ❑ Heart Disease	❑ ❑ Stroke	❑ ❑ Diabetes
❑ ❑ COPD	❑ ❑ Asthma	❑ ❑ Reflux	❑ ❑ Ulcers
❑ ❑ Kidney Disease	❑ ❑ Vascular Disease	❑ ❑ Hepatitis	❑ ❑ Blood Clots
❑ ❑ Bleeding Disorder	❑ ❑ Cancer	❑ ❑ Arthritis	❑ ❑ Seizures
❑ ❑ Headaches	❑ ❑ HIV		

❑ ❑ Other: _____

Past Surgical History ❑ (check all that apply)

❑ Appendectomy	❑ Gall Bladder	❑ Hernia	❑ Breast
❑ Heart Bypass	❑ Heart Valve	❑ Pacemaker	❑ Spine/Neck
❑ Arthroscopy	❑ Joint Replacement	❑ Rotator Cuff	❑ Hysterectomy

❑ Other: _____

Drug Allergies (list all known drug allergies)

_____

_____

Please complete both sides of form, sign and date.

Medications: (please list all prescription and over the counter medications and supplements)

❑ Separate List Attached

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Social History

❑ Single ❑ Married ❑ Divorced ❑ Widowed Children? ❑ NO ❑ YES # _____

Do you smoke? ❑ NO ❑ YES_____packs per day

Do you drink alcohol? ❑ NO ❑ YES Do you use drugs? ❑ NO ❑ YES (list) _____

What is your occupation? _____

Do you exercise regularly? ❑ NO ❑ Yes _____days per week

Do you participate in sports? ❑ NO ❑ YES (list) _____

Review of Systems

Do you currently or frequently have: q (check all that apply)

Constitutional

❑Weight loss
❑Weight gain
❑ Fever
❑ Chills

Eyes

❑ Blurred vision
❑ Double vision

Ears, Nose, Throat

❑ Hearing loss
❑ Ringing in ears
❑ Congestion
❑ Sore throat

Respiratory

❑ Shortness of breath
❑ Wheezing
❑ Cough
❑ Coughing blood

Cardiovascular

❑ Chest pain
❑ Palpitations

Genitourinary

❑ Painful urination
❑ Blood in urine
❑ Urgency/frequency
❑ Incontinence

Gastrointestinal

❑ Nausea
❑ Vomiting
❑ Diarrhea
❑ Constipation
❑ Incontinence

Skin

❑ Rash
❑ Skin lesion
❑ Nail problems

Neurological

❑ Headaches
❑ Seizures
❑ Dizziness
❑ Balance problems
❑ Numbness/tingling
❑ Weakness

Endocrine

❑ Thirst
❑ Tired/sluggish
❑ Hot
❑ Cold

Hematologic

❑ Bleeding problems
❑ Bruising
❑ Limb swelling

Psychiatric

q Depression
q Anxiety
q Insomnia
q Addiction
q Drug use

Musculoskeletal (other than current complaint)

q Joint pain (list) _____
_____
_____

❑ Back pain
❑ Neck pain
❑ Joint stiffness
❑ Joint swelling
❑ Gout

Other Medical Concerns: (list)

_____
_____
_____
_____

Height: _____
Weight: _____

Patient Signature:_____ Date: _____

Provider Signature:_____ Date: _____