Orthopaedic Associates of Zanesville
2854 Bell Street Zanesville, Ohio 43701 P: 740-454-3273 F: 740-588-1081 www.orthozane.com

SHOULDER PAIN QUESTIONNAIRE

Patient Name:_____ **DOB:**_____**Date:**_____

- Which shoulder is bothering you? Left Right Both
- Are you left handed or right handed? Left Right
- What type of work do you do? _____
- Did your shoulder pain start with a specific injury? Yes or No
  - If "yes": Date of injury: _____
  - Mechanism of injury: _____
  - Did you feel a pop or a snap with the injury? Yes or No
  - Is the injury work related? Yes or No
  - Is it the result of a car accident? Yes or No
- If there was no injury, did the pain start with a particular activity (such as baseball, tennis, painting, etc.)?
  - If "yes", what started the pain? _____
- If you did not have an injury, when did the pain start? _____
- What are your primary sports and/or activities? _____
- How do you describe your pain? _____
- How severe is it? (1-10 scale) _____
- Have you dropped items due to a shoulder condition? Yes or No
- Do any of the following increase your pain?
  - Sleeping on the affected shoulder: Yes Minimally No
  - Lifting your arm overhead: Yes Minimally No
  - Reaching out from your side: Yes Minimally No
  - Reaching behind your back: Yes Minimally No
  - Throwing motion: Yes Minimally No
  - Participating in sports: Yes Minimally No
  - Work activities: Yes Minimally No
  - Is there anything else that increases your pain? _____
    _____
- Do any of the following decrease your pain?
  - Rest: Yes Minimally No
  - Ice: Yes Minimally No
  - Heat: Yes Minimally No
  - Over the counter meds (Tylenol/Advil) Yes Minimally No
  - Prescription meds: Yes Minimally No
  - Is there anything else that decreases your pain? _____
    _____
- Does the pain move down your arm or up into your neck? Yes or No
- Do you have shoulder pain at night? Yes or No
- Do you have any of the following symptoms?

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SHOULDER PAIN QUESTIONNAIRE (cont'd)

- Clicking, popping, or grinding in your shoulder: Yes or No
- Weakness of your shoulder: Yes or No
- Weakness of your arm, elbow or hand: Yes or No
- Numbness or tingling in your arm or hand: Yes or No
- Stiffness of your shoulder: Yes or No
- Persistent or recurrent neck pain: Yes or No
- Are there any other symptoms regarding your shoulder that we should know about?

  _____

  _____

- Have you had any previous surgery to your shoulder? Yes or No
  If "yes" what type of surgery did you have and when did you have the surgery?

  _____

  _____

- Have you had any previous treatment for your shoulder pain such as:
  - Cortisone injections: Yes or No
  - Home exercises Yes or No
    When?_____ How long? _____
  - Physical Therapy: Yes or No
    When? _____ How long? _____
  - Chiropractic care: Yes or No
  - Acupuncture: Yes or No
  - Any other previous treatment for your shoulder pain?_____

    _____
- In general are your symptoms getting better, getting worse, or staying about the same?

  _____
- Have you had any x-rays taken of your shoulder? Yes or No
  - If yes: Date of x-ray:_____
    X-ray facility:_____
- Have you had an MRI of your shoulder? Yes or No
  - If yes: Date of MRI:_____
    MRI facility:_____

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SHOULDER PAIN QUESTIONNAIRE (cont'd)

CURRENT MEDICATIONS (include non-prescription meds and herbal supplements, etc.
(*If more than 14 medications, please list on a separate sheet)*

Name of Medication Dose How Often?	Name of Medication Dose How Often?

ALLERGIES:
Medications None _____ Yes _____
(Please describe)
_____
_____

Latex None _____ Yes _____
Metal None _____ Yes _____