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

SHOULDER HISTORY FORM

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Location of Problem:
- ☐ Right Shoulder
- ☐ Left Shoulder
- ☐ If both, is one worse than the other? ☐ Right ☐ Left

Approximate date problem began: _____

Please describe how long you have had your current problem:
- ☐ New injury or problem (of less than 6 weeks duration)
- ☐ Recent problem (6 weeks - 3 months duration)
- ☐ Chronic problem (problem has been treated for > 3 months & never returned to normal)
- ☐ Reinjury (injured same area before, received treatment, had no problems until this new injury) Date of re-injury_____

Is your problem the result of an injury? ☐ YES ☐ NO

What caused your injury?
- ☐ Fall ☐ Fighting
- ☐ Lifting ☐ Twisting
- ☐ Throwing ☐ Collision/Contact
- ☐ Reaching ☐ Other _____

Check any of the following that happened at the time of your injury:
- ☐ Felt Pain ☐ Heard a pop ☐ Had swelling ☐ Discoloration
- ☐ Dislocation ☐ Fracture ☐ Other _____

If your problem is the result of an injury, where did it occur? (Check only one)
- ☐ Home ☐ Work ☐ Motor Vehicle Accident
- ☐ Exercise ☐ Sporting Activity ☐ Other _____

Have you talked to a lawyer concerning your injury? ☐ Yes ☐ No

Are you receiving or have you applied for workers compensation concerning your injury? ☐ Yes ☐ No

Have you received previous treatment for your current problem? ☐ Yes (check all that apply below) ☐ No
- ☐ Medication _____
- ☐ Physical Therapy (where and when) _____
- ☐ Chiropractic treatment (when) _____
- ☐ Injections (when) _____
- ☐ Alternative treatment (ie: acupuncture)_____
- ☐ Xray (s) (where and when) _____
- ☐ MRI (where and when) _____
- ☐ Surgery (s) (What type, when, where) _____

Are you having pain today? ☐ Yes ☐ No

Is your pain today: ☐ Constant ☐ Occasional

On a scale of 0-10, how would you rate your pain today?

☐ 0 (no pain) ☐ 1,2,3 (mild pain) ☐ 4,5,6 (moderate pain) ☐ 7,8,9 (severe pain) ☐ 10- Worst pain imaginable

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Check the words that best describe the character of the pain you are having today:

☐ Aching ☐ Nagging ☐ Exhausting ☐ Miserable
☐ Unbearable ☐ Tender ☐ Stabbing ☐ Shooting
☐ Sharp ☐ Gnawing ☐ Penetrating ☐ Tiring
☐ Burning ☐ Numb

Does the pain awaken you from sleep? ☐ Never ☐ Occasionally ☐ Frequently
Does the pain keep you from falling asleep? ☐ Never ☐ Occasionally ☐ Frequently

What time of day is your pain the worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ All of the time

What makes your pain WORSE: ☐ Ice ☐ Lying Down ☐ Sitting ☐ Rest ☐ Walking ☐ Heat ☐ Medication ☐ Standing ☐ Nothing ☐ Other_____

What makes your pain BETTER: ☐ Ice ☐ Lying Down ☐ Sitting ☐ Rest ☐ Walking ☐ Heat ☐ Medication ☐ Standing ☐ Nothing ☐ Other_____

SOCIAL HISTORY:

Current employment: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Unemployed ☐ Disabled

Job Title: _____

Highest level of education completed:
☐ Grade school ☐ High school/equivalent ☐ Some college ☐ College degree ☐ Graduate degree

ALLERGIES:

Are you allergic to any medications? ☐ YES (list below) ☐ NO

_____
_____

CURRENT MEDICATIONS:

Please list the medications you are currently taking. Please list both prescribed and non prescribed medications. Please list the doses and number of times taken daily.

_____
_____
_____
_____
_____

Please check any of the anti inflammatory medications you have taken in the past:

☐ Advil ☐ Naprelan ☐ Other _____
☐ Arthrotec ☐ Naproxen
☐ Daypro ☐ Celebrex For how long have you been taking these? _____
☐ Ibuprofen ☐ Tylenol
☐ Lodine ☐ Ultram

Please check any of the side effects you experienced while taking any of the above anti-inflammatories:

☐ Nausea ☐ Diarrhea ☐ Gastric ulcers ☐ Upset stomach ☐ Vomiting ☐ Other _____

Please check any of the following medications you take on a regular basis?

☐ Aspirin ☐ Axid ☐ Coumadin ☐ Cytotec ☐ Heparin ☐ Maalox
☐ Mylanta ☐ Prevacid ☐ Pepcid ☐ Zantac ☐ Tagamet ☐ Prilosec

Person completing this form: _____
Relationship to patient: _____