ATLANTIC ORTHOPAEDIC SPECIALISTS
Leaders in Orthopaedic Health

Date: _____

Jennifer M. Byrd, MD
NEW PATIENT EVALUATION FORM
SHOULDER

I. PATIENT DATA

Name: _____ Age: _____ DOB: _____

E-mail: _____ Occupation: _____

Telephone Number: _____ Referring Physician:_____

Cell Phone Number: _____ PCP: _____

Pharmacy: _____ Height: _____ Weight: _____

II. HISTORY OF YOUR PROBLEM

1. Which shoulder is the problem? Left Right Dominant Hand: Left Right
2. When did your symptoms begin? ___/___/_____
3. Is your shoulder problem the result of an injury? Y / N
   a. If yes, is it (circle): Workman's Comp, Auto Accident, Litigation Pending
   b. Briefly describe injury: _____
      _____
4. Concerns (circle): Pain, Weakness, Loss of Motion, Instability, Numbness/Tingling
   a. If instability, how many times have you dislocated? _____ Last Dislocation? _____
5. Where is the pain located? (circle all that apply) FRONT / BACK / SIDE / TOP / ARM / DEEP / SHOULDER BLADE / NECK / OTHER:_____
6. Describe the pain (circle): Dull, Achy, Sharp, Burning, Throbbing, Tingling, Other:_____
7. Is the pain associated with (circle): pain waking you at night, pain radiating up or down, neck or back pain, other _____
8. Please rate the severity on a scale of 1 to 10: Now: _____ At it's worst: _____
9. What makes it better? (circle): Rest, Ice, Elevation, Medication, Other _____
10. What makes it worse? (circle): Overhead activity, reaching behind, Other _____
11. Previous Treatment: _____
12. Previous Injury: _____
13. Previous surgery: _____
14. What activities are you involved in? (circle): football, basketball, soccer, volleyball, running, cycling, yoga, swimming, tennis, golf, other _____
    a. What level? (circle): high school, college, semi-pro, professional, recreational
    b. Frequency? _____

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III: PAST MEDICAL HISTORY

1. Have you ever had any of the following: Check all that apply, provide explanation in space below.

□ High Blood Pressure	□ Lung Disease	□ Autoimmune Disorder	□ Gout
□ High Cholesterol	□ Pacemaker	□ Liver Disease/Hepatitis	□ Stomach Ulcer
□ Diabetes	□ Arthritis	□ Fibromyalgia	□ Stroke
□ Neurological Disease	□ Anxiety/Depression	□ Blood Clot	□ HIV/AIDS
□ Kidney Disease	□ Cancer	□ Bleeding Disorder	□ Major Infection
□ Heart Disease	□ Sleep Apnea	□ Blood Transfusion	□ Thyroid Disease

Explain: _____
_____
_____

2. Have you had surgery before? What? _____
3. Allergies? _____
4. What medications and dosages are you taking? _____
   _____

IV: Social History

1. Occupation? _____
2. Do you smoke? _____ If so, how much? _____
3. Do you drink alcoholic beverages? _____ If so, how much? _____

Office Use Only:

Atrophy:_____
AROM: _____ ?Painful?
PROM: _____
TTP:
AC joint _____
Subdeltoid bursa_____
Coracoid _____
Bicipital Groove_____

Strength:
Scaption: _____/5_
Subscap: _____/5_
ER: _____/5_
Hawkins: _____
Neer:_____
Apprehension: _____
Relocation: _____
Jerk:_____

Speeds: _____
Obrien's:_____
Cross body: _____

Contralateral shoulder
Cervical Spine