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Name: _____ DOB: _____ Age: _____ M ☐ F ☐

Referring Provider: _____ Occupation: _____

HEALTH SCREENING: Please answer the following questions and **explain all yes answers**.

Are you currently taking blood thinners?	No	Yes	
Have you had an infection after surgery?	No	Yes	
Have you ever had a blood clot?	No	Yes	
Any problems with anesthesia?	No	Yes	Describe:_____
Complication following surgery?	No	Yes	Describe:_____
Do you have an allergy to Latex?	No	Yes	
Do you have a metal allergy?	No	Yes	Describe:_____
What was your last HA1C?	N/A		Value:_____
Do you use a walker or cane?	No	Yes	
Do you use a CPAP machine?	No	Yes	Pressure setting: _____
Do you live at home alone?	No	Yes	
Are you able to climb a flight of stairs without stopping?	No	Yes	
Have you had a heart attack (MI) within the last 2 years?	No	Yes	
Have you been hospitalized in the past 6 months?	No	Yes	

MEDICAL HISTORY: Please ensure **ALL** medical conditions are checked or listed

☐	Hypertension/High blood pressure	☐	Diabetes	Other conditions not covered
☐	Heart disease/coronary artery disease	☐	Rheumatoid arthritis	
☐	Irregular Heart beat/arrhythmia	☐	Gout	
☐	High cholesterol	☐	Osteoporosis	
☐	Peripheral vascular disease	☐	Thyroid disease	
☐	Stroke	☐	Reflux disease/Heartburn	
☐	Sleep apnea	☐	Stomach ulcers	
☐	Asthma	☐	Cancer	
☐	COPD/Emphysema	☐	kidney disease	
☐	Blood clots/abnormal clotting	☐	HIV/AIDS	
☐	Abnormal bleeding	☐	Hepatitis	

FAMILY HISTORY: If **yes** please explain

Do you have a family history of blood clots or easily bleeding?	No	Yes
Do you have a family history of problems with anesthesia?	No	Yes
Any other family history you would like to share?	No	Yes

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MEDICATIONS: Please list or attach ***ALL*** prescription ***AND*** over the counter medications

Name / Dose	How often	Name / Dose	How often
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

MEDICATION ALLERGIES: Please list all allergies and state reaction

Medication: **Reaction** (what happened)	**Medication**: **Reaction** (what happened)
1.	3.
2.	4.

SURGICAL HISTORY: Please include all surgeries you have had in the past

PROCEDURE:	Year:	PROCEDURE:	Year:
1.		4.	
2.		5.	
3.		6.	

REVIEW OF SYSTEMS: Do you **CURRENTLY** have any of the following conditions

General (Fever, chills, weight loss/gain)	No	Yes	Digestion (Reflux, ulcers, pain)	No	Yes
Eyes	No	Yes	Bowels (Constipation, diarrhea)	No	Yes
Ears/Nose/Throat	No	Yes	Appetite, Weight gain/loss, weakness	No	Yes
Heart (Chest pain, palpitations, murmur)	No	Yes	Skin (Rashes, sores, itching)	No	Yes
Lungs, breathing	No	Yes	Balance, dizziness, numbness, tingling	No	Yes

Please explain all yes answers here:

SOCIAL HISTORY:

Marital Status: Married ☐ Single ☐ Widow(er) ☐ Divorced ☐
Are you currently working? Yes ☐ No ☐ Retired
Do you drink alcohol? Yes ☐ No ☐ How much? (circle) rarely occasionally daily weekly
Do you currently smoke or vape? Yes ☐ No ☐ How much? _____ packs per day for _____ years
Quit ☐ (Year you quit:_____) _____ packs per day for _____ years
History of substance abuse? Yes ☐ No ☐ If yes, what substance:

Patient Signature _____ Date _____

Reviewing M.D/PA_____ Date _____

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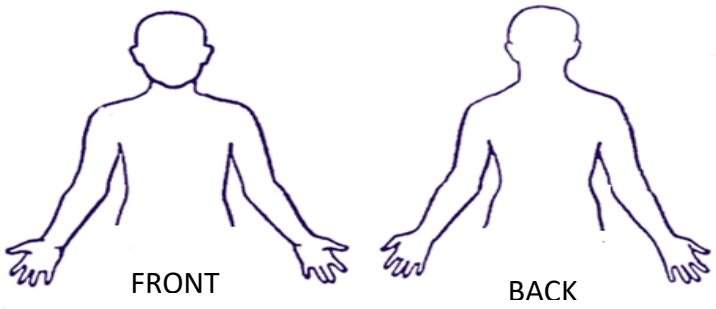
(Medical Staff Only)
Patient Label

New Patient Questionnaire

(Place an X on the diagram for pain and an N for numbness)



Circle or write responses to the questions below:

Which hand do you write with? Right *or* Left

Which side are we treating? Right Left Both

How would you describe symptoms? Pain *or* Instability *or* Weakness

How long have you had symptoms? (fill)_____

Did the symptoms start with an injury? No *or* Yes
If yes, describe:_____

How often are the symptoms? Constant *or* Come and go

How Severe is the Pain MOST of the Time? (No Pain) 0 – 1- 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Worse pain)

What makes the symptoms worse? ☐ Lifting
☐ Raising the arm above shoulder level
☐ Reaching behind
☐ Sleeping on the shoulder
☐ Ot_____

ShouC1aE1bNP

What treatments have you tried?

- ☐ Anti-inflammatories (Aleve, Ibuprofen, etc.)
  If so, how many?_____
- ☐ Prescription pain medication
- ☐ Physical therapy or strengthening
- ☐ Injections (list number)_____
- ☐ Surgery (list)_____
- ☐ Other (list)_____

For each activity, choose the answer that indicates your ability to do the following activities: (Mark with an X)

	Unable to do	Very Difficult to do	Somewhat Difficult	Not Difficult
1. Put on a coat				
2. Sleep on your painful or affected side				
3. Wash back/do up bra in back				
4. Manage toileting				
5. Comb hair				
6. Reach a high shelf				
7. Lift 10 lbs. above shoulder				
8. Throw a ball overhand				
9. Do usual work				
10. Do usual sport				

How unstable is your shoulder (stable) 0 – 1- 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (unstable)

In general, how would you rate your overall health? (circle one below)

Excellent *Very Good* *Good* *Fair* *Poor*

How would you rate your shoulder today as a percentage of normal? (0% to 100%) _____