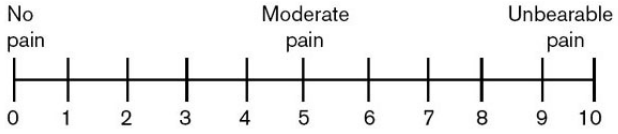
UCSF Orthopaedic Surgery

SHOULDER HISTORY AND PHYSICAL

Name: **Age**: **Date**:

What side is the problem? ☐ Left ☐ Right ☐ Both **What side do you write with?** ☐ Left ☐ Right	[Patient Sticker]
Height: **Weight:**	
Circle a number from 0-10 that best describes how much pain you are having **RIGHT NOW.** 	For a child or non-english speaking adult, use the FACES© pain rating scale below: 

Who were you referred by?	☐ I was not referred by another provider
Who is your primary care physician?	☐ I do not have a primary care physician
What is the reason for your visit today?	
Have you completed diagnostic studies regarding this issue? (Ex: MRI, x-ray, CT, etc.)	

Pre-Operative Screening: ☐ ***NONE OF THE BELOW***

☐ Alcohol Abuse or Dependence	☐ Coronary Artery Disease	☐ MRSA Infection/Colonization
☐ Anemia	☐ Deep Vein Thrombosis	☐ Myocardial Infarction
☐ Asthma	☐ Diabetes Mellitus	☐ Opioid Dependence
☐ Blood Transfusion	☐ Hepatitis	☐ Pulmonary Hypertension
☐ Cancer	☐ HIV/AIDS	☐ Sickle Cell Anemia
☐ CHF	☐ Hypertension	☐ Stroke
☐ Cirrhosis	☐ Kidney Disease	☐ Substance Abuse
☐ Clotting Disorder	☐ Liver Disease	☐ TIA
☐ COPD	☐ Other	☐ Other

Past Medical History: ☐ ***NONE OF THE BELOW***

☐ Allergies	☐ Anesthetic Complications	☐ Ankylosing Spondylitis
☐ Anxiety	☐ Arthritis	☐ Baker's Cyst
☐ Bleeding Disorder	☐ Blood Disorder	☐ Bone Cyst
☐ Bursitis	☐ Carpal Tunnel	☐ Depression
☐ Fibromyositis	☐ Fractures	☐ Ganglion Cyst
☐ GERD	☐ Glaucoma	☐ Heart Disease
☐ Intestinal Disease	☐ Kyphosis	☐ Nerve/Muscle Disease
☐ Osteoarthritis	☐ Osteoporosis	☐ Paget's Disease of Bone
☐ Scoliosis	☐ Seizures	☐ Sinus Disorder
☐ Skin Disease	☐ Spondylolisthesis	☐ Thyroid Disease
☐ Ulcer	☐ Autoimmune Disorder	☐ Other

Past Surgical History:

	Date		Date		Date
☐ Abdomen Surgery		☐ Foot Fracture Surgery		☐ Knee Arthroscopy	
☐ Ankle Fracture Surgery		☐ Foot Surgery		☐ Knee Surgery	
☐ Back Surgery		☐ Hand Surgery		☐ Laminectomy	
☐ Carpal Tunnel Release		☐ Heart Surgery		☐ Shoulder Arthroscopy	
☐ Elbow Fracture Surgery		☐ Hip/Femur Fracture Surgery		☐ Shoulder Surgery	
☐ Other		☐ Joint Replacement		☐ Wrist fracture Surgery	

Family History:

☐ Anesthesia Problems	☐ Diabetes	☐ Osteoporosis	☐ Cancer
☐ Lupus	☐ Rheumatoid Arthritis	☐ Clotting Disorders	☐ Osteoarthritis

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Do you smoke? ☐ Yes ☐ No ☐ Smokeless Tobacco Packs per day: _____ Years of use: _____ Quit Date: _____	**Alcohol Use:** ☐ Yes ☐ No Drinks/Week: _____
History of substance use: ☐ Yes ☐ No Last use date: _____ If yes, what type? _____	

Review of Systems: If you currently have any symptoms, please circle any that apply:

☐ **NONE OF THE BELOW**

Constitutional: Fever, Chills, Weight Loss, Malaise/Fatigue, Diaphoresis/Sweating

Skin: Rash, Itching

HENT: Hearing loss, Ringing in ears, Ear pain, Ear Discharge, Nosebleeds, Congestion, Sinus pain, Stridor, Sore throat

Eyes: Blurred vision, Double vision, Photophobia, Eye pain, Eye discharge, Eye redness

Cardiovascular: Chest pain, Palpitations, Orthopnea, Claudication, Leg swelling, Paroxysmal Nocturnal Dyspnea

Respiratory: Cough, Hemoptysis, Mucus production, Shortness of breath, Wheezing

Gastrointestinal: Heartburn, Nausea, Vomiting, Abdominal pain, Diarrhea, Constipation, Blood in stool

Genitourinary: Dysuria, Urgency, Frequency, Hematuria, Flank pain

Musculoskeletal: Myalgias, Neck pain, Back pain, Joint pain, Falls

Endocrine/Hematologic/Allergic: Easy bruising, Environmental allergies, Polydipsia/Excessive thirst

Neurological: Dizziness, Headaches, Tingling, Tremors, Sensory Change, Speech Change, Focal weakness, Seizures

Psychiatric: Depression, Suicidal ideations, Anxiety, Insomnia, Memory loss

When did you start to have pain?

Was there a specific injury (if so, what happened)?

Have you ever dislocated your shoulder? ☐ Yes ☐ No

If yes, was it reduced in the ER or on your own? _____

How many times has your shoulder dislocated? _____

Please list any previous shoulder surgeries below:

Where do you feel the pain?

☐ Top of the shoulder ☐ Back of the shoulder
☐ Front of the shoulder ☐ Radiating down the arm

Does the pain shoot down into the hand? ☐ Yes ☐ No
Do you have numbness or tingling in the hand? ☐ Yes ☐ No
Do you have pain in your neck? ☐ Yes ☐ No

What previous treatments have you tried: ☐ None

☐ NSAIDS *(Motrin, Ibuprofen)* Helpful? ☐ Y ☐ N
☐ Narcotics *(Codeine, Vicodin)* Helpful? ☐ Y ☐ N
☐ Physical Therapy Helpful? ☐ Y ☐ N
☐ Injections Helpful? ☐ Y ☐ N
☐ Surgery Helpful? ☐ Y ☐ N

What makes the pain better?

What makes the pain worse?

How do you describe the pain?

☐ Dull ☐ Aching ☐ Sharp ☐ Throbbing

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Occupation?	**Marital Status?**
What sports/activities do you participate in?	
Have you fallen since your last visit or within the last year? ☐ Yes ☐ No If yes, did your fall result in an injury? ☐ Yes ☐ No Please describe: _____	

Medications: Please list **ANY** and **ALL** medications you are currently taking. ☐ **I am not taking any medications.**

Medication	Dosage	Frequency	Route of Administration

Drug Allergies: Please list all drug allergies or adverse reactions to medications ☐ **I have no known drug allergies.**

Medication	Reaction

UCSF Patient Assessment

Who do you live with?

☐ Alone ☐ Caregiver ☐ Child(ren) ☐ Family ☐ Friends ☐ Group Home

☐ Homeless ☐ Foster Care ☐ Legal Guardian ☐ Parent ☐ Roommate(s) ☐ Sr Housing

☐ Shelter ☐ Significant Other ☐ Skilled Nursing ☐ Spouse ☐ Other_____

How do you (or your caregiver) learn best (check all that apply)?

☐ Listening ☐ Reading ☐ Demonstration ☐ Pictures/Video ☐ Declined

Do you (or your caregiver) have any barriers to learning (check all that apply)? ☐ No barriers

☐ Reading ☐ Language ☐ Cultural ☐ Visual ☐ Hearing

☐ Physical ☐ Emotional ☐ Cognitive ☐ Spiritual ☐ Financial

Do you (or your caregiver) have any cultural or religious practices or spiritual beliefs that we should be aware of?

☐ Yes ☐ No ☐ Declined

If yes, please describe: _____

In the last 12 months, have you been hurt or felt threatened by someone close to you? ☐ Yes ☐ No