NewportCare®
MEDICAL GROUP

# PATIENT HISTORY
## FOR ORTHOPAEDICS

Dr. Cheung New Patient Shoulder Questionaire: Occupation: _____

Name _____ Age: _____

1. Dominant hand: ☐ Right ☐ Left
2. How long have you had pain in the shoulder? _____ months _____ years
3. Was there an injury? ☐ No ☐ Yes: Description (include date of injury)_____

_____

4. Have you ever dislocated your shoulder? ☐ Yes ☐ No
5. Do you have any previous surgeries to the shoulder? ☐ No ☐ Yes. Description (include approximate dates):

_____

6. Does pain radiate? ☐ Yes ☐ No

   If so, where does it radiate ? ☐ Neck ☐ Shoulder blades ☐ Elbow ☐ Hand Other: _____
7. Type of pain: ☐ Sharp ☐ Dull/aching ☐ Tingling/Electric ☐ Burning ☐ Throbbing
8. Severity of pain from 0-10 scale (0 none, 10 maximum): _____
9. Degree of disability: ☐ None ☐ Slight/occasional ☐ Mild with no effects on activities
   ☐ Moderate but tolerable ☐ Marked with serious limitations ☐ Totally disabling
10. Do you have pain with overhead activities? ☐ Yes ☐ No
11. Do you have pain with dressing and activities of daily living? ☐ Yes ☐ No
12. Do you have pain at night when you sleep? ☐ Yes ☐ No
13. Does the pain wake you up at night? ☐ No ☐ Yes. (Please describe frequency, i.e. once per night, or 2-3 times per week, etc) _____
14. What interventions have you had recently for the shoulder? ☐ Narcotics ☐ Tylenol
    ☐ Anti-inflammatory medications ☐ Physical therapy Other: _____

Degree of relief from the above: ☐ None ☐ Minimal ☐ Moderate ☐ Good

15. How many steroid injections have you had for the shoulder? _____

How much pain relief? ☐ None ☐ Minimal ☐ Moderate ☐ Good

How long pain relief? _____ weeks _____ months _____ years

16. Please circle if you have any: ☐ Painful Locking ☐ Painful Clicking ☐ Painless clicking
17. Any swelling? ☐ Yes ☐ No
18. Aggravating factors: _____
19. Relieving factors: _____

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