NEWPORT ORTHOPEDIC INSTITUTE

PAGE ONE TO BE FILLED OUT BY PATIENT

NAME:____________________ AGE:______ SEX: M/F DATE:__/__/__ Refer MD:___________
Occupation: __________

AFFECTED SHOULDER:(circle)
Right Left

DOMINANT SIDE: (circle)
Right Left Ambidextrous

Do you have pain?	Yes	No	If yes, for how long?:______
Did you have a specific injury?	Yes	No	If yes, when? Date: _______
Have you had recurrent injuries?	Yes	No	If yes, how many?:________
Did you injure your shoulder playing sports?	Yes	No	If yes, sport?:____________
Does or has your shoulder dislocated?	Yes	No	If yes, number of times:____

Please describe the injury and activity at the time of the original injury and currents symptoms: (use the back if necessary)

____

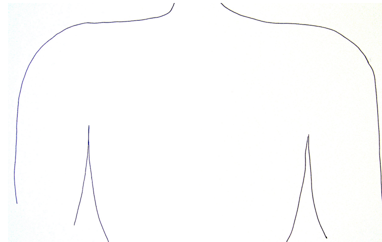
____

____

____

Where is your pain? Please circle area: Right Left

Front
Back
Side
Arm



Does your pain wake you from sleep?	Yes	No	
Do you have difficulty reaching above your head?	Yes	No	
Have you lost range of motion?	Yes	No	
Are you diabetic?	Yes	No	

What medications are you taking for your pain? ______________________________________

Have you done physical therapy for your shoulder?	Yes	No	
Have you had a cortisone injection?	Yes	No	If yes, when and how many?
Have you had shoulder surgery?	Yes	No	If yes, please describe:

____

Do you have any numbness or tingling?	Yes	No	If yes, where:_____
Do you have a history of neck surgery?	Yes	No	

Current Medications: (please supply list or write down)

____

____

Drug Allergies: ____

Do you smoke? Yes No Packs Per Day:____ Years:_____