



PERFORMANCE

ORTHOPAEDICS • SPORTS MEDICINE • SHOULDER SURGERY • PHYSICAL THERAPY

NEW PATIENT SHOULDER QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. How were you referred to Dr. DiGiulio?
2. Who is your Primary Care Physician?
3. What is your AGE?
4. What is your occupation?
5. RIGHT or LEFT shoulder?
6. Are you RIGHT or LEFT Handed?
7. Do you perform regular exercise?
8. When did your shoulder symptoms start?
9. Did you have a specific INJURY to your shoulder? (If so, please BRIEFLY describe)?

10. If so, was your injury WORK RELATED?

PRIOR TO YOUR CURRENT SHOULDER PROBLEMS...

11. Have you had any previous shoulder PROBLEMS? (if so, please BRIEFLY describe)

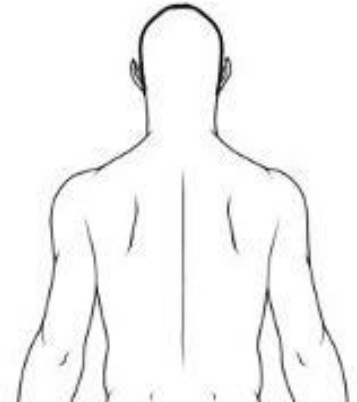
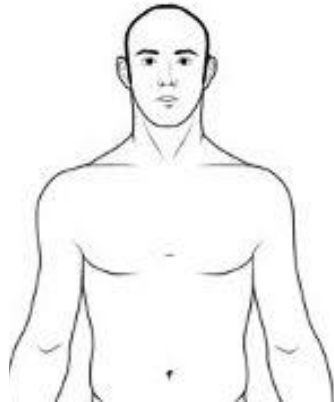
12. Have you had any previous shoulder INJURIES? (i.e. dislocation, fracture, etc.)

13. Have you had any previous shoulder SURGERY? (if so, please list along with dates)

YOUR SYMPTOMS:

14. WHERE does your shoulder hurt?
(please mark the area)

15. Rate your pain on a scale of 1-10:



16. WHEN does your shoulder hurt? (circle all that apply)



PERFORMANCE

ORTHOPAEDICS • SPORTS MEDICINE • SHOULDER SURGERY • PHYSICAL THERAPY

All the time

Sleeping on the shoulder

Reaching overhead

Reaching behind you

- Please list any other activities that cause your shoulder to hurt:

Reaching across your body

Throwing

Lifting

17. Does your shoulder make any noise while moving? (such as popping, clicking, crunching)?
18. Does your shoulder catch or lock?
19. Does your shoulder feel loose, or come out of joint?
20. Do you have reduced motion?
21. Do you have reduced strength?
22. Do you have numbness/tingling down your arm? (If yes, please describe where, i.e. forearm, hand, fingers)
23. Do you have pain down your arm? (If yes, please describe where, i.e. forearm, hand, fingers)

TREATMENT:

24. Have you had evaluation and/or treatment for your shoulder prior to today's office visit?

IF NO, please skip to **IMAGING** section below...

IF YES, please circle which treatment(s) you have had:

- Are you taking NSAID's? (type & frequency)
- Shoulder exercises at home
- Physical therapy
- Cortisone injection
- Surgery
- Please list any other treatments:

IMAGING:

25. Have you had imaging of your shoulder prior to today's office visit?

IF YES, please circle and describe results if you know them.

XRAY

ULTRASOUND

MRI

- Please list any other imaging: