Vital Signs Height____ (inches) Weight____ (lbs) ____ T_____ BP____/____ P ____

Joint Preservation Institute, 2825 J St., #440 Sacramento, CA 95816	New Patient Shoulder Questionnaire
Referring Physician Name & Address (if different from primary care physician)	Primary Care Physician Name & Address

Today's Date

Name: (Last, First, M.I.) _____	☐ **M** ☐ **F**	**Date of Birth** **Age**

History of Present Illness

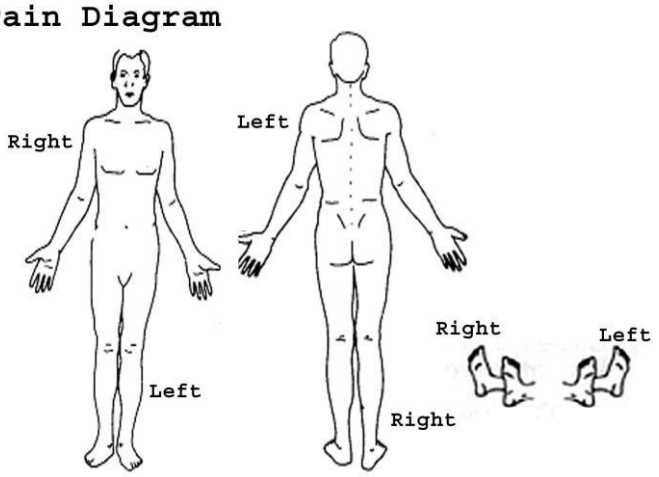
What part of your body is driving you to seek medical attention?
☐Shoulder ☐Arm ☐Elbow ☐ OTHER

Which side?

If you have an injury to the affected part, when did it occur?

How did the injury or accident happen?

Pain Diagram



No Pain — **Worst Pain of My Life**

0 5 10

What makes your pain better? (rest, ice, heat, massage, medications)	
What makes your pain worse? (activity, walking, running, bending, squatting)	
What is the quality of your pain (sharp, dull ache, burning, other)	
How many hours a day do you have this pain?	
Do you have pain at rest?	☐Yes ☐No
Does the pain radiate to anywhere else? If yes, where?	
Do you have any of the following?	
swelling ☐Yes ☐No	popping or clicking ☐Yes ☐No
numbness ☐Yes ☐No	giving way ☐Yes ☐No
What limitations of your daily routine do you have due to this injury?	
Have you injured this area prior to this injury? If so, explain.	
Do you have difficulty with overhead activity	☐Yes ☐No
Do you have difficulty feeding yourself?	%
Do you have difficulty with other daily activities?	☐Yes ☐No
Have you had physical therapy?	☐Yes ☐No If so where and for how long?
What other treatments have you had for your current condition?	☐Acupuncture ☐TENS unit ☐Other?
Cortisone injections? If yes, when and how often?	☐Yes ☐No Explain
Viscosupplementation? (Synvisc, Hyalgan) If yes, when and how often?	☐Yes ☐No Explain
Do you take any antiinflammatory medications?	☐Yes ☐No
Do you take Chondroitin Sulfate and Glucosamine?	☐Yes ☐No
Can you put on your shoes and socks?	☐Yes ☐No
Can you cut your toenails yourself?	☐Yes ☐No

Review of Systems: Check if you have had, or currently have any of the following symptoms and the date of onset

	Symptom	Date of Onset
☐	Fevers	
☐	Chills	
☐	Night Sweats	
☐	Rashes/Frequent Itching	
☐	Sores that don't heal	
☐	Hearing Loss	
☐	Nasal Problems	
☐	Difficulty Swallowing	
☐	Thyroid Problems	
☐	Weight Loss	
☐	Weight Gain	
☐	Excessive sweating	
☐	Tremor	
☐	Chest Pain	
☐	Shortness of Breath	
☐	Cough	
☐	Enlarged Heart	
☐	Irregular Heart Beat	
☐	Heart Murmur	
☐	Wheezing	
☐	Vein Problems	
☐	Others:	

	Symptom	Date of Onset
☐	Phlebitis	
☐	AIDS	
☐	Hepatitis B	
☐	Hepatitis C	
☐	Previous Deep Vein	
☐	Transient Ischemic	
☐	Seizures	
☐	Calf Pain on Exertion	
☐	Easy Bruisability	
☐	Swollen Nodes	
☐	Paralysis	
☐	Weakness	
☐	Numbness	
☐	Tingling in Arms or	
☐	Painful Urination	
☐	Frequent Urination	
☐	Bloody Urine	
☐	Bleeding Ulcers	
☐	Hiatal Hernia	
☐	Frequent Indigestion	
☐	Colitis	

Please list any known medical conditions or problems.	**Year of onset**

Please list surgeries that you have undergone.	**Year performed**

Please list any over the counter or prescribed medications.		
Drug Name	Strength or Dose	Taken when and how often?

Medication Allergies: ☐ No Known Allergies OR	1. 2. 3.

Social and Activity History: This information may impact your health insurance. If you have any concerns about this please leave the information blank and discuss it verbally with your physician to ensure confidentiality.			
Smoking (Tobacco)		**How many per day?**	**How many years?**
Cigarettes	☐Yes ☐No		
Alcohol	☐Yes ☐No		
Illicit Drugs	Are you currently using or have you used any illicit drugs such as methamphetamine or cocaine? ☐Yes ☐No		
	Have you ever used intravenously injected drugs such as heroin? ☐Yes ☐No		
Highest Grade of School Completed	☐Elementary ☐HighSchool ☐College ☐Post-Graduate		
Occupation			
Marital Status	☐Single ☐Married ☐Divorced ☐Widowed ☐Other		

Hobbies/Activities/Sports	How many hours a week do you perform these activities?

FAMILY HISTORY: Please list any illnesses of family members or cause of death if known.				
	Age	Mark X if Alive and Well	Mark X if deceased	Describe family member illness or cause of death if known
Mother				
Father				
Siblings				
Children				