ROPER ST. FRANCIS
PHYSICIAN PARTNERS
Orthopaedic Surgery & Sports Medicine

New Patient Intake- Shoulder, Elbow/Upper Extremity

Patient Name: _____
DOB: _____ Age: _____ Referred by: _____

Reason for Today's Visit:

☐ Right shoulder ☐ Left Shoulder ☐ Right Elbow ☐ Left Elbow ☐ Other (Wrist, Forearm, etc.): _____

Please describe, what you hope to achieve or take away from today's appointment: _____

_____

Check one of the following:

☐ No Injury- estimated date symptoms began: _____

☐ Injury- date of injury: _____

If injury:

Do you have neck pain? ☐ YES ☐ NO
Numbness/tingling in arms? ☐ YES ☐ NO
Did you experience immediate swelling? ☐ YES ☐ NO
Is this a sports related injury? ☐ YES ☐ NO Sport: _____

What is your dominant hand? ☐ LEFT ☐ RIGHT

Do you have pain at night? ☐ YES ☐ NO

Check all symptoms that apply.

Numbness__	Tingling__	Stiffness__	Locking__
Swelling__	Throbbing__	Instability__	Catching__
Weakness__	Popping__	Aching__	Constant__
Sharp pains__	Shooting Pains__	Stabbing Pains__	Dull Pain__

Other: _____

Duration (Ex: Intermittent, Constant): _____ Length of Time: _____

What makes it worse? _____
What makes it better? _____

Previous Treatment:

Have you had any recent imaging? (to include shoulder or cervical spine) ☐ YES ☐ NO

If yes, (circle one)

Type of Imaging: X Ray MRI CT

Date Performed: _____ Facility: _____

Have you had any previous surgical procedures to this extremity? ☐ YES ☐ NO

If yes, Procedure: _____ Date: _____ Provider: _____

Have you had any prior cervical spine surgeries? ☐ YES ☐ NO **(FOR SHOULDER PATIENTS ONLY)**

If yes, Procedure: _____ Date: _____ Provider: _____

What treatments have you tried, if any? (Check all that apply)

Cortisone Injections__ Physical Therapy__ Warm Compresses__
Icing__ Voltaren Gel__ Other_____

Have you tried any over the counter medications? (Check all that apply)

Aleve__ Advil__ Aspirin__
Tylenol__ Ibuprofen__
How often do you take these medications? _____

Have you experienced complications with any type of anesthesia? (Check all that apply or fill in the blank)

General__ IV Sedation__ Local anesthesia__
Dental anesthesia__ Other: _____

Medical/Social History:

Do you have any blood relatives with osteoporosis or arthritis? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO Do you drink? ☐ YES ☐ NO
If yes, how many packs a day_____ If yes, how much in a week _____

Allergies: *Please list any additional allergies below.*

Medication	Date Noted/Reaction

Medications: *Please list any medications you are currently taking including over-the-counter medication.*

Medication Name	Dosage

Pain Scale: **FOR SHOULDER PATIENTS ONLY**

Please describe which point on the scale from 0= no pain to 10= the worst pain imaginable, best describes the pain you are experiencing in each of the following situations:

At its worst?
0 1 2 3 4 5 6 7 8 9 10
When lying on the involved side?
0 1 2 3 4 5 6 7 8 9 10
Touching the back of your neck?
0 1 2 3 4 5 6 7 8 9 10
Reaching for something on a high shelf?
0 1 2 3 4 5 6 7 8 9 10
Pushing with the involved arm?
0 1 2 3 4 5 6 7 8 9 10

Disability Scale:

Please describe the degree of difficulty, on a scale from 0= no difficulty to 10= so difficult it requires help while performing the following activities:

Washing your hair?
0 1 2 3 4 5 6 7 8 9 10
Washing your back?
0 1 2 3 4 5 6 7 8 9 10
Putting on a shirt?
0 1 2 3 4 5 6 7 8 9 10
Putting on a shirt that buttons down the front?
0 1 2 3 4 5 6 7 8 9 10
Putting on your pants?
0 1 2 3 4 5 6 7 8 9 10
Placing an object on a high shelf?
0 1 2 3 4 5 6 7 8 9 10
Carrying a heavy object of 10lbs?
0 1 2 3 4 5 6 7 8 9 10
Removing something from your back pockets?
0 1 2 3 4 5 6 7 8 9 10