Beaumont

Shoulder Questionnaire

Name: ____ Age: _____________ Weight: ___________

Which shoulder(s) bothers you? Right Left

How long has this been going on? ____ ________

Do you know what caused the problem? If yes, describe: ____

____

Have you ever had surgery or arthroscopy to your shoulder? Right Left
If yes when and where? ____
Describe: ____

Have you had any x-rays _____, CAT scan (CT) _____, Ultrasound _____, MRI _____ of your shoulder? Right Left
If yes, when and where? ____
Did you submit any of the above exams for comparison? Yes No
If no, can you submit these for comparison to today's exam? Yes No

If you have shoulder pain, describe it:
(circle all that apply)
Dull Aching Sharp
Constant Intermittent

Pain when moving arm
-above the level of your shoulder Yes No
-reaching behind your back Yes No

Pain mostly at -
Night day all day

Pain travels down arm Yes No
Neck pain Yes No

How bad is the pain? _____
(on a scale from 1 to 10, where 1 = minimal pain, 10 = terrible pain)

Do you have any -
numbness/tingling in arm? Yes No
numbness/tingling in hand? Yes No
weakness in arm? Yes No
weakness in hand? Yes No
loss of motion? Yes No

Does your shoulder ever
- feel loose? Yes No
- slip in and out of its socket? Yes No
- get stuck or lock? Yes No
- catch, pop or lock? Yes No

Can you lift your arm above your head? Yes No
Did you ever dislocate your shoulder? Yes No Not sure
Did you ever fracture your shoulder? Yes No Not sure

Does your job involve any repetitive arm/shoulder movement? If yes, describe:
____

Do you exercise or play sports? If yes, describe: ____
____

Did you ever have steroid injections to your shoulder? Right Left If yes, when? __________

Do you take any medications for your shoulder problem? If yes list: _____________________________
____

Do you have history of any cancer? If yes describe: ____

Please add anything else that you think might be important:______________________________________
____

List any other medications, medical problems or surgeries. _______________________________________
____

Medicine allergies ____
Latex allergies ____

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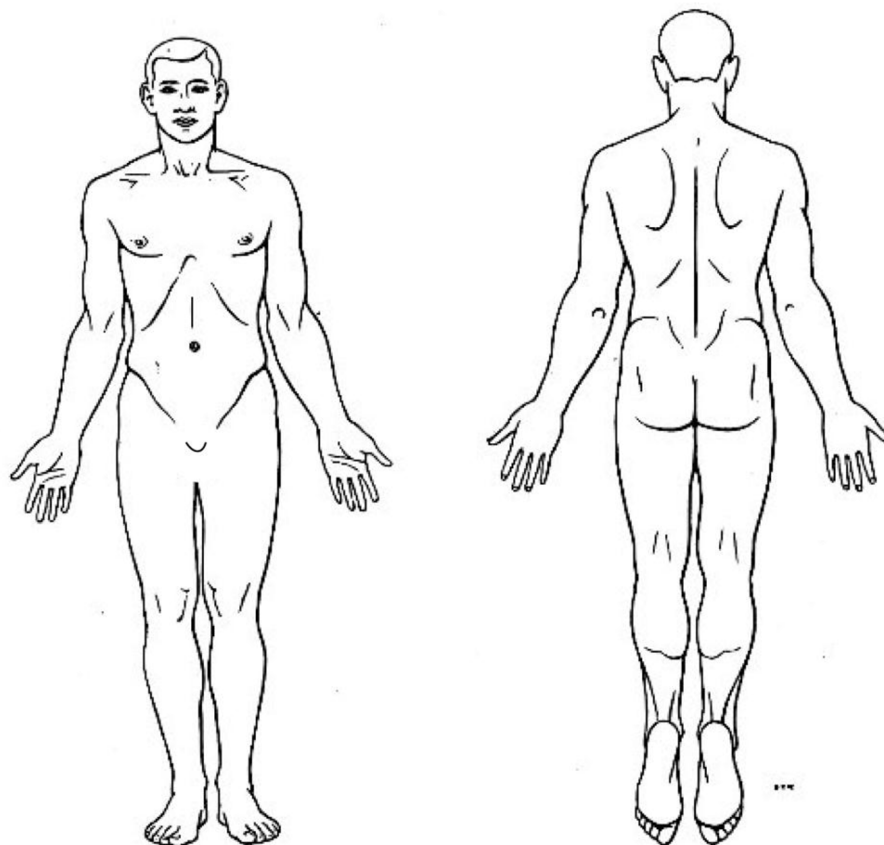

Using the figures, please shade in the areas affected by pain and/or numbness. Please be precise.