JOHNS HOPKINS
MEDICINE

Patient's ID sticker will go here

New Shoulder Patient Questionnaire

Patient phone number _____ Patient email address _____

Referral source _____ Ok to email you? ☐ No ☐ Yes

Primary care physician (PCP) _____ PCP Phone _____

CURRENT PROBLEM

Describe your current limitations _____

_____

Are you? ☐ Right-handed ☐ Left-handed ☐ Both Current problem? ☐ Right ☐ Left ☐ Both shoulders

Date problem began _____ Duration: ☐ Days ☐ Weeks ☐ Months ☐ Years

Did you injure yourself? ☐ No ☐ Yes

If yes how? ☐ Sports ☐ Car accident ☐ Fall ☐ Work/job

☐ Other _____

Is there a workers' comp claim? ☐ No ☐ Yes

Is there litigation involved? ☐ No ☐ Yes

Are you currently working? ☐ No ☐ Yes Occupation _____

Describe your pain: ☐ Ache ☐ Deep ☐ Throbbing ☐ Shooting

☐ Sharp ☐ Burning ☐ Tingling

When do you have pain? ☐ At rest ☐ Overhead activities ☐ With sports

☐ At night ☐ Falling asleep

Is your pain: ☐ Worsening ☐ Improving ☐ No change

☐ Radiating to hand ☐ Radiating up neck

How long does your pain last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Constant

What makes your problem better? _____

What makes your problem worse? _____

Do you have associated: ☐ Clicking/catching ☐ Stiffness ☐ Swelling

☐ Numbness ☐ Weakness

MEDICATIONS

Have you taken medication for the current problem? ☐ No ☐ Yes If yes, list dosage and duration

Medication	Dosage	Duration	Outcome
			☐ Helped a little ☐ A lot ☐ Not at all
			☐ Helped a little ☐ A lot ☐ Not at all
			☐ Helped a little ☐ A lot ☐ Not at all
			☐ Helped a little ☐ A lot ☐ Not at all

PREVIOUS TREATMENTS FOR THIS PROBLEM

Have you had any injections (cortisone) for this problem? ☐ No ☐ Yes

How many?_____ How long did it last?_____ ☐ Helped a little ☐ A lot ☐ Not at all

Have you had physical therapy for this problem? ☐ No ☐ Yes

How often? _____ For how long? _____ ☐ Helped a little ☐ A lot ☐ Not at all

Have you had any previous surgery for this problem? ☐ No ☐ Yes

Year	Type of Surgery	Surgeon	Outcome
			☐ Helped a little ☐ A lot ☐ Not at all
			☐ Helped a little ☐ A lot ☐ Not at all
			☐ Helped a little ☐ A lot ☐ Not at all

Have you experienced any of the following? Please check all boxes that apply to you.

- ☐ Good general health
- ☐ Wound problems: (redness/swelling/drainage)
- ☐ Chills
- ☐ Fevers
- ☐ Night sweats
- ☐ Leg pain
- ☐ Leg swelling
- ☐ Rash
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Fainting
- ☐ Palpitations
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Speech problems
- ☐ Urinating problems
- ☐ Bowel problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stomach problems
- ☐ Reflux/GERD
- ☐ Heartburn

COMPREHENSIVE SHOULDER ASSESSMENT

Please rank your shoulder's condition with respect to the following categories.
If only one shoulder is problematic, indicate which shoulder: ☐ RIGHT ☐ LEFT
If both shoulders are problematic, label each slash ("/") with "R" for right or "L" for left. See example.

EXAMPLE for problems affecting both shoulders

Category	Make a single slash ("/") along the line	
Overall Shoulder Assessment	Worse it could possibly be	Normal
Range of Motion	No ROM	Full/Normal ROM
Strength	No strength	Full/Normal Strength
Stability	No stability (easily dislocates, feels "loose")	Normal Stability
Activities of Daily Living (personal hygiene, dressing, sleeping, eating)	Unable to do	Able to perform all ADLs
Sports and Leisure Activities	Unable to do	Able to perform all desired activities
Effect of Shoulder Condition on Mental Well-being	Worse possible distress (anxiety, sadness, stress)	No distress

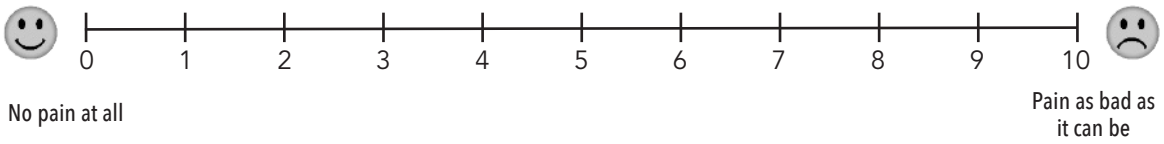
SHOULDER ASSESSMENT FORM – AMERICAN SHOULDER AND ELBOW SURGEONS

Check the number in the box that indicates your ability to do the following activities:
0 = Unable to do 1 = Very Difficult 2 = Somewhat Difficult 3 = Normal

Activity	LEFT Arm	RIGHT Arm
1. Put on a coat	☐ 0 ☐ 1 ☐ 2 ☐ 3	☐ 0 ☐ 1 ☐ 2 ☐ 3
2. Sleep on your painful or affected side	☐ 0 ☐ 1 ☐ 2 ☐ 3	☐ 0 ☐ 1 ☐ 2 ☐ 3
3. Wash back/do up bra in back	☐ 0 ☐ 1 ☐ 2 ☐ 3	☐ 0 ☐ 1 ☐ 2 ☐ 3
4. Manage toileting	☐ 0 ☐ 1 ☐ 2 ☐ 3	☐ 0 ☐ 1 ☐ 2 ☐ 3
5. Comb/Wash hair	☐ 0 ☐ 1 ☐ 2 ☐ 3	☐ 0 ☐ 1 ☐ 2 ☐ 3
6. Reach a high shelf	☐ 0 ☐ 1 ☐ 2 ☐ 3	☐ 0 ☐ 1 ☐ 2 ☐ 3
7. Lift 10 pounds above shoulder	☐ 0 ☐ 1 ☐ 2 ☐ 3	☐ 0 ☐ 1 ☐ 2 ☐ 3
8. Throw a ball overhand	☐ 0 ☐ 1 ☐ 2 ☐ 3	☐ 0 ☐ 1 ☐ 2 ☐ 3
9. Do usual work- List:	☐ 0 ☐ 1 ☐ 2 ☐ 3	☐ 0 ☐ 1 ☐ 2 ☐ 3
10. Do usual sport- List:	☐ 0 ☐ 1 ☐ 2 ☐ 3	☐ 0 ☐ 1 ☐ 2 ☐ 3

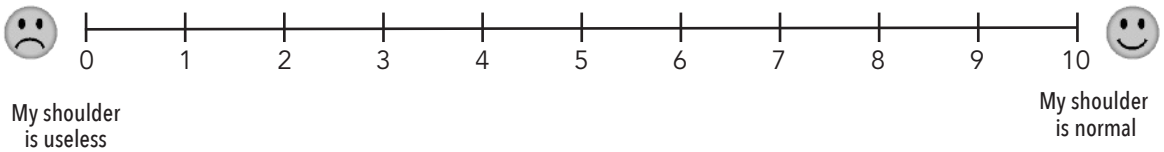
PAIN

On the following scale of 0-10, please **circle** your answer. **How bad is your pain today?**



FUNCTION

On the following scale of 0-10, please **circle** what you consider to be the most current **overall function of your shoulder.**



TODAY'S HEALTH

We would like to know how good or bad your health is TODAY.

Under each heading, please check the ONE box that best describes your health TODAY.

Mobility

- ☐ I have no problems walking
- ☐ I have slight problems walking
- ☐ I have moderate problems walking
- ☐ I have severe problems walking
- ☐ I am unable to walk

Self-Care

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

Pain / Discomfort

- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

Anxiety / Depression

- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed

The scale to the right is numbered from 0 to 100.

100 means the **best** health you can imagine.

0 means the **worst** health you can imagine.

Mark an X on the scale to indicate how your health is TODAY.

Now, please write the number you marked on the scale in the box below.

Your Health Today