WESTERN ORTHOPAEDICS
1830 Franklin Street, Suite 450
Denver, Colorado 80218

MRN: _____

Dr. Hatzidakis Follow Up Form

TODAY's DATE: _____

PATIENT INFORMATION *(please fill out before your visit): Your Primary Care MD* _____

Your Name: _____ *Your Age:* _____

Any changes in medical history? _____

1. *Which shoulder bothers you today? RIGHT LEFT BOTH NEITHER*
2. *How has your shoulder progressed since last visit? BETTER WORSE SAME* ***Percent of normal***_____*%*
3. *Where is your shoulder pain located? BACK FRONT SIDE DEEP ARM ARMPIT* _____
4. *How would you describe the pain? ACHING BURNING SHARP DULL IRRITATING* _____
5. *How SEVERE is the pain, on a scale of 0 (no pain) to 10 (worst pain ever)?* _____
6. *How long does the pain last, and when does it occur?* _____
7. *What makes the pain better?* _____ *Worse?* _____
8. *What medicines are you taking for the pain, and how much/often? (please list all specific medicines and doses)* _____
9. *Any numbness or tingling? If yes, where?* _____ *Any fevers, night sweats or chills?* _____
10. *Any other comments or things we should know?* _____

Your signature and date please: _____

PHYSICIAN/PA EXAMINATION (for physician only) F/U S/P R L B

_____A&O x 4, appropriate, ambulates normally. _____Skin no lesions/signs infection/incisions healed/sutures

R L B Elbow/ Wrist/ Fingers AROM full without crepitation/weakness/instability R L B Fingers NVI M/S M/R/U

R L B Elbow AROM/PROM Flexion-Exten Arc _____ PRO _____ Sup _____

R L B Shoulder AROM full without crepitation/weakness/instability with exception of _____

R L B Shoulder AROM/PROM FF_____AB_____ER0_____IR_____

R L B Tenderness at ACJ LHB LT GT None_____Relocation_____
Apprehension_____ O"Brien_____LO_____ BP_____

R/L/B Sh Strength testing (out of 5) FF_____ AB_____ JobesAB_____ER0_____IR_____

OTHER FINDINGS _____

NOTES _____

Imaging: _____

A / P: _____ F/U _____

Approximately_____minutes or longer was spent with the patient today, over half of this was spent counseling the patient regarding their findings and options for treatment

Provider Signature/Date: _____

Shoulder Arthroplasty Pre-op

Strength Test: R_____L_____ lbs
(Indicate "0" if patient cannot reach 90° FF)

External Rotation:
R L
❍/❍ None of the movements are pain free
❍/❍ Hand behind head & elbow forward
❍/❍ Hand behind head & elbow back
❍/❍ Hand above head & elbow forward
❍/❍ Hand above head & elbow back
❍/❍ Full elevation of arm

SPOT – Subjective Patient Outcome Tracker®

DATE: ____/_____/_____ NAME: _____ MRN: _____

For the following questions, please indicate what percent satisfaction you have regarding ***BOTH*** of your ***SHOULDERS***

0% = TERRIBLE/Not satisfied at all **100% = GREAT**/Completely satisfied

(Or ***choose A NUMBER between 0 and 100*** to show your level of satisfaction)

1. How satisfied are you with the ***comfort (lack of pain)*** in your shoulder ***when you are not using it***?

Right ____ % Left ____ %

2. How satisfied are you with the ***comfort (lack of pain)*** in your shoulder ***during or after activity***? (e.g. work, school, chores, sports)

Right ____ % Left ____ %

3. How satisfied are you with your ability to ***sleep through the night*** without your shoulder bothering you*?*

Right ____ % Left ____ %

4. How satisfied are you with the ***mobility ('range-of-motion')*** of your shoulder?

Right ____ % Left ____ %

5. How satisfied are you with the ***stability (how secure it feels in its socket)*** of your shoulder?

Right ____ % Left ____ %

6. How satisfied are you with the ***strength*** of your shoulder?

Right ____ % Left ____ %

7. How satisfied are you with your shoulder's ability to do ***your regular chores and/or everyday activities***?

Right ____ % Left ____ %

8. How satisfied are you with your shoulder's ability to do ***your regular work activities***? (write N/A if you do not work or are retired)

Right ____ % Left ____ %

9. How satisfied are you with your shoulder's ability when you do ***your regular fitness/exercises/sports***? (write N/A if this does not apply)

Right ____ % Left ____ %

10. How satisfied are you ***with getting through the day and not feeling worried or frustrated*** about your shoulder?

Right ____ % Left ____ %

OFFICE USE ONLY
RIGHT:
□ Non-Operative
□ Pre-Operative
□ Post-Operative
Date of Sx:
_____
Procedure:
_____

LEFT:
□ Non-Operative
□ Pre-Operative
□ Post-Operative
Date of Sx:
_____
Procedure:
_____

Thank you for completing this questionnaire!