**Appointment Date:**   **Time:**

**Brent Morris, M.D.**

**Fondren Orthopedic Group, LLP**

**7401 South Main**

**Houston, TX 77030**

**\*Arrive 30 minutes prior to your scheduled appointment\***

Please complete the enclosed medical questionnaire and mail/fax

(281-501-5970) or e-mail back to: [pecss@fondren.com](mailto:pecss@fondren.com) **prior** to your scheduled appointment.

Please bring your driver’s license and insurance card or information with you to your appointment as we will be unable to see you without proof of identity.

This information will help us deliver the best possible medical care.

If you have had the following test you will need to bring these to your appointment for Dr. Morris to review:

1. X-ray reports
2. X-rays films or CD
3. MRI reports
4. MRI films or CD
5. Medical records related to the shoulder problem.
6. If you feel surgery may be needed, please bring if available any recent EKG, lab work, list of current medications, list of prior surgeries, and list of allergies.

If you find that you are unable to keep your appointment, please notify our office at your earliest convenience. Our telephone number is 713-799-2300 or our toll free number 1-800-590-3627.

Thank you for your cooperation.

Carina Silva

The office staff for Brent Morris, M.D.

Patient Name:­­­­­­­ Appointment date:

E-mail Address:

Referred by:

(Doctor’s name and phone #) FAX #

**CHIEF COMPLAINT**

Which shoulder is painful?

Right Left Both shoulders equal

Right more painful than Left Left more painful than Right

**Patient history**

Height: Weight:

Are you? Right handed Left handed Use both hands equally

What kind of work do you do?

How long have you had your shoulder problem?

     # days      # weeks      #months      #years

How did it begin? suddenly gradually

What caused your shoulder problem?

An accident A motor vehicle accident

a period of strenuous activity after an injury

I don’t know

Is your shoulder pain?

Getting worse staying about the same getting better

How does your shoulder feel? Check all that apply.

It hurts

It feels weak

It feels stiff

It feels loose

It feels like it slips

It catches or locks in certain positions

It grinds or pops

It aches

there is a burning sensation

It feels like it is in spasm

I have tingling or numbness in my fingers

­­

Before this shoulder problem started, were you having any problems with your shoulder?

yes no

**Painful Activities**

I have recently injured my shoulder and have severe pain that prevents me from using it.

I have **shoulder** pain with the following activities. Please check all that apply.

using an ATM machine

getting a parking ticket

reaching in the back seat of the car

putting on the seatbelt

washing a car

turning the steering wheel

adjusting car mirror or radio

performing gardening/yard work

performing housework

vacuuming

pulling up bed covers

sleeping

doing the laundry

starting a lawnmower

putting a belt through the belt loops

reaching my wallet

fastening a bra

Buttoning pants

putting on a coat/shirt/sweater

combing hair

blow drying hair

Lifting

pushing / pulling

Knitting/crochet

doing computer work/typing

pouring from pitcher

getting milk from the refrigerator

reaching overhead

reaching out to the side

carrying heavy objects

**SPORTS**

Do you have **shoulder** pain with any of the following sports?

Please check all that apply.

golf hockey

tennis racquetball

swimming basketball

bowling weight lifting

softball volleyball

baseball

**How has your shoulder been treated up to now?**

# I have

NOT changed my work to adjust for my shoulder

changed my work to adjust for my shoulder

stopped working to adjust for my shoulder

what kind of work?

**For my shoulder problem I have already seen**

my regular doctor a chiropractor an orthopedic surgeon

a neurosurgeon a physical therapist a massage therapist

Your general health and medications can affect your treatment. Please help us by providing the following information

**Do you have a Family Physician or Internist??** Yes No

Doctor: FAX #

Date of last visit Date of last complete examination

Would you like us to send a copy of our report to the doctor you listed above??

Yes No

Another doctor?

Address:

**MEDICATION**

I have **not** taken any medication for my shoulder condition

I **was** treated with medication

Name of medication

**INJECTIONS**

I have **not** received an injection for my shoulder condition

I **have** received an injection

**THERAPY**

I have **not** had any therapy for my shoulder condition

I **have** received therapy for my shoulder condition

Date therapy started and duration: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGERY**

I have **not** had any surgery for my shoulder condition

I **have** had any surgery for my shoulder condition

Date and type of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** Please provide any pertinent family medical history relating to your parents

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Illness/condition | Father | Mother | Age at diagnosis | Living?  If no, date of death |
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Unknown

# Medical problems (Review of Systems)

ROS Heart

No heart problems

Heart attack

Blocked arteries in the heart

Congestive heart failure

Palpitations

Murmur

Cardiomyopathy

Pericarditis

Cardiomegaly

Aortic aneurysm

A-fib

Conduction disorder

Atrial flutter

Mitral insufficiency

hypertensive heart disease

Angina

Mitral Valve Prolapse

Rheumatic heart disease

Cardiac pacemaker

ROS Vascular

No vascular problems

Anemia

Hypotension (low blood pressure)

Fainting

Hypertension (high blood pressure)

Phlebitis

varicose veins

Vasovagal

Venous insufficiency

DVT (deep venous thromobosis)

ROS Lungs

No lung problems

Asbestosis

asthma

bronchitis

COPD

emphysema

PE (pulmonary embolism)

pneumonia

pneomothorax

shortness of breath

Sleep apnea

ROS Gastrointestinal

No GI problems

Achalasia

anorexia

C diff

colitis

Crohn’s

diverticulitis

ulcer

reflux

fecal incontinence

gastric bypass

gastritis

hiatal hernia

Irritable bowel syndrome

pancreatitis

ROS Hepatitis

Hepatitis A (year\_\_\_\_\_\_\_)

Hepatitis B (year\_\_\_\_\_\_\_)

Hepatitis C (year\_\_\_\_\_\_\_)

Hepatitis type unknown

acute

chronic

past resolved

ROS Genitourinary

No GU problems

Acute renal failure

Chronic renal failure

cystitis

dialysis

kidney stones

urinary incontinence

ROS Neurologic

No neurological problems

Alzheimer’s

Carpal tunnel syndrome

Cerebral Palsy

Dementia

Diabetic neuropathy

Epilepsy

ROS Psychological

No psychological problems

Alcoholism

Anxiety

Bipolar disorder

Depression

Drug dependence

Eating disorder

Insomnia

Obsessive-compulsive disorder

Panic attacks

Phobias

Schizophrenia

Paraplegia

Parkinson’s

Peripheral neuropathy

Migraines

Polio

Seizures

Stroke

TIA’s

ROS Endocrine

No Endocrine problems

Diabetes non-insulin dependent

Diabetes insulin dependent

Graves

Addison’s

Gout

Hypothyroidism

ROS Infection

No infectious disease problems

HIV

AIDS

TB

MRSA

ROS ENT (Ear, Nose and Throat)

No HEENT problems

Dystonia

Hearing Aid

Hearing Loss

Sinusitis

Vertigo (positional)

ROS Eyes

No eye problems

Blindness

Cataracts

Glaucoma

Macular degeneration

Retinopathy

ROS Skin

No skin problems

Cellulitis

Eczema

Psoriasis

Rosacia

Shingles

ROS Breast

No breast problems

Benign Mass

Cyst

Fibrocystic Disease

Mastitis

Breast Cancer

# Do you have any allergies??

To medicines NO YES Describe:

Metal Allergy: NO YES Type of Metal:

To iodine x-ray dye shellfish latex

**Pharmacy Name**(and address if known)**:**

**Pharmacy Phone #:**

**Please list the medications you are currently taking**

I am **not** currently taking any medication

I am taking the following medication.

Medication Dosage times/day

1.

2.

3.

4.

## Social History

The amount you drink and smoke can affect how well bones and ligaments heal and how you react to medicines or anesthesia.

Alcohol

I do not drink

I am a social drinker

I am a daily drinker

      Beers / day       Beers / week

      Glasses of wine / day       Glasses of wine / week

      Liquor drinks / day       Liquor drinks / week

Tobacco

I do not smoke I smoked but stopped

      year stopped smoking

I smoke

      packs per day for       number of years

      cigars / week

I chew tobacco