**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 **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