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

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