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.
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 like it slips
It feels weak It catches or locks in certain positions
It feels stiff It grinds or pops
It feels loose 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
- tennis
- swimming
- bowling
- softball
- baseball
- hockey
- racquetball
- basketball
- weight lifting
- volleyball

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

<table>
<thead>
<tr>
<th>Illness/condition</th>
<th>Father</th>
<th>Mother</th>
<th>Age at diagnosis</th>
<th>Living? If no, date of death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 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 Lungs
- No lung problems
- Asbestosis
- Asthma
- Bronchitis
- COPD
- Emphysema
- PE (pulmonary embolism)
- Pneumonia
- pneumothorax
- 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 Vascular
- No vascular problems
- Anemia
- Hypotension (low blood pressure)
- Fainting
- Hypertension (high blood pressure)
- Phlebitis
- Varicose veins
- Vasovagal
- Venous insufficiency
- DVT (deep venous thrombosis)

### 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

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  
Rosacea  
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.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>times/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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