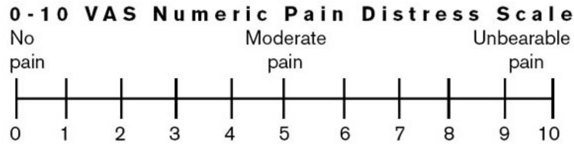
Michael P. Leathers, MD

Orthopaedic Surgeon Specializing in
Sports Medicine/Shoulder, Hip and Knee Reconstruction

SHOULDER HISTORY AND PHYSICAL

Name: **Age**: **Date**:

What side is the problem? ☐ Left ☐ Right ☐ Both **What side do you write with?** ☐ Left ☐ Right	**Email Address:**
Height: **Weight:**	
Circle a number from 0-10 that best describes how much pain you are having **RIGHT NOW.**	For a child or non-english speaking adult, use the FACES© pain rating scale below:
	

Please list any **ALLERGIES** you have to medications or food/substances	☐ None
Please list **prescription medications** on the **ATTACHED** sheet or check "None"	☐ None

Check the Box if you have: ☐ *NONE OF THE BELOW*

☐ Alcohol Abuse or Dependence	☐ Coronary Artery Disease	☐ MRSA Infection/Colonization
☐ Anemia	☐ Deep Vein Thrombosis	☐ Myocardial Infarction
☐ Asthma	☐ Diabetes Mellitus	☐ Opioid Dependence
☐ Blood Transfusion	☐ Hepatitis	☐ Pulmonary Hypertension
☐ Cancer	☐ HIV/AIDS	☐ Sickle Cell Anemia
☐ CHF	☐ Hypertension	☐ Stroke
☐ Cirrhosis	☐ Kidney Disease	☐ Substance Abuse
☐ Clotting Disorder	☐ Liver Disease	☐ TIA
☐ COPD	☐ Other	☐ Other

Past Medical History: ☐ *NONE OF THE BELOW*

☐ Allergies	☐ Anesthetic Complications	☐ Ankylosing Spondylitis
☐ Anxiety	☐ Arthritis	☐ Baker's Cyst
☐ Bleeding Disorder	☐ Blood Disorder	☐ Bone Cyst
☐ Bursitis	☐ Carpal Tunnel	☐ Depression
☐ Fibromyositis	☐ Fractures	☐ Ganglion Cyst
☐ GERD	☐ Glaucoma	☐ Heart Disease
☐ Intestinal Disease	☐ Kyphosis	☐ Nerve/Muscle Disease
☐ Osteoarthritis	☐ Osteoporosis	☐ Paget's Disease of Bone
☐ Scoliosis	☐ Seizures	☐ Sinus Disorder
☐ Skin Disease	☐ Spondylolisthesis	☐ Thyroid Disease
☐ Ulcer	☐ Other	☐ Other

Past Surgical History:	Date		Date		Date
☐ Abdomen Surgery		☐ Foot Fracture Surgery		☐ Knee Arthroscopy	
☐ Ankle Fracture Surgery		☐ Foot Surgery		☐ Knee Surgery	
☐ Back Surgery		☐ Hand Surgery		☐ Laminectomy	
☐ Carpal Tunnel Release		☐ Heart Surgery		☐ Shoulder Arthroscopy	
☐ Elbow Fracture Surgery		☐ Hip/Femur Fracture Surgery		☐ Shoulder Surgery	
☐ Elbow Surgery		☐ Humerus Fracture Surgery		☐ Spinal Fusion	
☐ Other		☐ Joint Replacement		☐ Wrist fracture Surgery	

Family History:

☐ Anesthesia Problems	☐ Diabetes	☐ Osteoporosis	☐ Cancer
☐ Lupus	☐ Rheumatoid Arthritis	☐ Clotting Disorders	☐ Osteoarthritis

Physician Signature____Date_________________

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Do you smoke? ☐ Yes ☐ No ☐ Smokeless Tobacco
Packs per day: ____________ Years of use: ___________
Quit Date: ____________

Alcohol Use: ☐ Yes ☐ No
Drinks/Week: ______________________

History of illegal drug use: ☐ Yes ☐ No Last use date: __________ If yes, what type? _________________________

Check and explain if you have any of the following symptoms **CURRENTLY**:

☐ **NONE OF THE BELOW**

☐ Headache, dizziness, visual problems ______________________________________
☐ Ear, nose or throat problem ______________________________________
☐ Chest pain, irregular heartbeat, palpitations ______________________________________
☐ Lung problems, asthma, shortness of breath ______________________________________
☐ Difficulty or frequent urination ______________________________________
☐ Nausea, vomiting, diarrhea, heartburn ______________________________________
☐ Loss of sensation in your arms or legs ______________________________________
☐ Vascular disease ______________________________________
☐ Diabetes, thyroid or other endocrine problems ______________________________________
☐ Easy bruising ______________________________________
☐ Fevers, chills, night sweats ______________________________________
☐ Recent weight loss or gain ______________________________________

When did you start to have pain?

Was there a specific injury (if so, what happened)?

Have you ever dislocated your shoulder? ☐ Yes ☐ No

If yes, was it reduced in the ER or on your own? _______________

How many times has your shoulder dislocated? ________________

Please list any previous shoulder surgeries below:

Where do you feel the pain?

☐ Top of the shoulder ☐ Back of the shoulder
☐ Front of the shoulder ☐ Radiating down the arm

Does the pain shoot down into the hand? ☐ Yes ☐ No
Do you have numbness or tingling in the hand? ☐ Yes ☐ No
Do you have pain in your neck? ☐ Yes ☐ No

What previous treatments have you tried: ☐ None

☐ NSAIDS *(Motrin, Ibuprofen)* Helpful? ☐ Y ☐ N
☐ Narcotics *(Codeine, Vicodin)* Helpful? ☐ Y ☐ N
☐ Physical Therapy Helpful? ☐ Y ☐ N
☐ Injections Helpful? ☐ Y ☐ N
☐ Surgery Helpful? ☐ Y ☐ N

What makes the pain better

What makes the pain worse?

Does the shoulder pain wake you up in the night?
☐ Yes ☐ No

How do you describe the pain?
☐ Dull ☐ Aching ☐ Sharp ☐ Throbbing

Occupation?

What sports/activities do you participate in?

Sport	Level	Hours/Week	Weeks/Year

What questions can I answer for you today?
1. ____
2. ____
3. ____

Physician signature_________________________________Date____________

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SACRAMENTO ORTHOPEDIC CENTER
2801 K Street, Suite 330
Sacramento, CA 95816
(916) 732-3000

NAME: ____ DATE: _______________________

CURRENT MEDICATION SHEET

Please list your medications, including any over the counter medications such as Asprin, Advil, Aleve, Tylenol, etc. Please list all natural vitamins, supplements and herbs that you take.

MEDICATION	DOSE	FREQUENCY (How often you take)

Physician Signature____Date__________________