

# NEW PATIENT ASSESSMENT FORM

## (SHOULDER)

**GARY A. PATTEE, M.D., INC.**

**ORTHOPAEDIC SURGERY**

**DISORDERS OF THE SHOULDER AND ARTHROSCOPY**

375 ROLLING OAKS DR. SUITE 200, THOUSAND OAKS, CALIFORNIA 91361

(805) 497-9481 Fax (805) 497-3416

Date \_\_\_\_\_

Referred by \_\_\_\_\_

Name (Print) \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

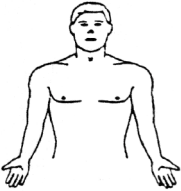
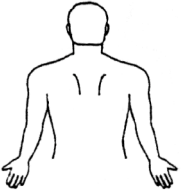
Address (Home) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_

(Business) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Right/Left Handed (circle) \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Current Condition	Please Print or Write Answer	Physician Notes
For <b>what</b> condition or problem are you being seen at this time?		Atrophy/Deformity _____  AROM Flexion Abd Ext Rot Int Rot Acc. STM  PROM = sl> nl  X-rays Office _____ Outside (date: _____)  MRI/MRA (date: _____)  U/S (date: _____)  Diagnosis:  Plan:  Follow-up:
When did the injury occur or when did the symptoms or condition first begin?		
Briefly describe <b>how</b> the injury occurred or <b>how</b> the symptoms developed?		
Is this <b>new</b> or have you had similar symptoms in the past? Please describe.		

Are you having <b>pain</b> in your shoulder or arm? (circle the correct answer)	Yes	No
Mark where your <b>pain</b> is: <div style="display: flex; justify-content: space-around; align-items: center; margin-top: 10px;">   </div>		
How <b>severe</b> is your pain currently (mark line)? <div style="display: flex; align-items: center; margin-top: 10px;"> <div style="margin-right: 10px;">0</div> <div style="flex-grow: 1; border-bottom: 1px solid black; position: relative;"> <div style="position: absolute; left: 50%; top: -50%; transform: translate(-50%, -50%);">5</div> <div style="position: absolute; right: 0; top: -50%; transform: translate(50%, -50%);">10</div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>No pain at all</span> <span>Pain as bad as it can be</span> </div>		

Does your shoulder condition <b>awaken</b> you at night?	Yes	No
Do you take <b>pain medication</b> for your shoulder?	Yes	No
If yes, please list the <b>specific medications</b> used for pain: _____		
How many pills do you take each day (average)? _____ pills		

Please check any of the following that make your pain worse:

Reaching above the shoulder or over the head

Reaching behind your back

Sleeping on the affected side

Reaching to the other shoulder

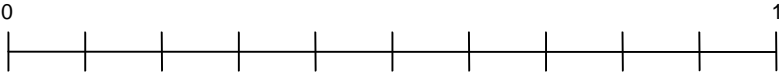
Lifting 10 pounds above the shoulder

Throwing a ball overhand

Do you notice any of the following symptoms when moving your shoulder (please circle)?

Crunching, Grinding, Clicking, Snapping, Popping, Catching, Locking

Other (describe): \_\_\_\_\_

Does your shoulder feel <b>unstable</b> (as if it is going to dislocate)?	Yes	No
How unstable is your shoulder (mark line)?		
<div style="display: flex; justify-content: space-between; align-items: center;"> <span>0</span>  <span>10</span> </div>		
<div style="display: flex; justify-content: space-between;"> <span>Very <b>stable</b></span> <span>Very <b>unstable</b></span> </div>		

Regarding your shoulder, have you had any of the following?				
<b>Evaluation</b> by a another doctor	Yes	No	When?	
<b>X-rays</b>	Yes	No	When?	
<b>MRI Scan</b>	Yes	No	When?	
<b>Cortisone injections</b> If <b>yes</b> , did this help?	Yes	No	When? <span style="float: right;">How many?</span>	
	Yes	No	If yes, how much better was the pain? _____% How long did it last? _____	
<b>Physical Therapy</b>	Yes	No	When?	
<b>Shoulder Surgery</b>  If <b>yes</b> , did this help?	Yes	No	When? Describe:	
	Yes	No	Were there any problems associated with the surgery? Describe:	Yes

Do you have or have you had problems with your <b>neck</b> (pain, ruptured disk, pinched nerve, etc.)? Please describe:	Yes	No
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Do you have <b>numbness and/or tingling</b> around the shoulder or down the arm?	Yes	No
Mark where you <b>numbness and/or tingling</b> is:		

**Please circle any of the following illnesses you have had or now have and explain below. Also list any not included:**

- |                     |                  |                    |                    |
|---------------------|------------------|--------------------|--------------------|
| Heart disease       | Kidney disease   | Neurologic disease | Emotional disorder |
| Heart attack        | Liver disease    | Mental illness     | Bleeding problems  |
| Irregular heartbeat | Ulcers/gastritis | Chronic infections | Anemia             |
| High blood pressure | Colitis          | Cancer             | Skin problems      |
| Stroke              | Lung disease     | Diabetes           | Hernia             |
| Blood clots         | Asthma           | Arthritis          | Other _____        |

**Explain:** \_\_\_\_\_  
\_\_\_\_\_

<b>Surgery/Hospitalizations:</b>	<b>When or at what age?</b>
_____	_____
_____	_____
_____	_____
_____	_____

**Allergies/Medication Intolerances:**  
\_\_\_\_\_  
\_\_\_\_\_

Medications	Dose/Amount	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Social History**

Marital Status:	Single _____	Married _____	Other _____
Alcohol:	None _____	Occasional _____	Regularly _____
Tobacco	None _____	Yes (packs/day) _____	
Coffee	None _____	Yes (cups/day) _____	
Harmful Substances/Drugs	_____		

**Family History**

	<b>Age</b>	<b>Diseases/Conditions or Cause of Death if Deceased</b>
Father	_____	_____
Mother	_____	_____
Brother(s)	_____	_____
	_____	_____
	_____	_____
Sister(s)	_____	_____
	_____	_____
	_____	_____
Other	_____	_____
	_____	_____
	_____	_____

**Please circle any of the following symptoms you have and list any not included:**

**General:** Recent weight loss; fever; chills; sleep disorder

**Eyes/Vision:** Loss or change of vision; double vision; blurred vision; eye diseases; redness; watering

**Ears, Nose, Throat:** Hearing loss; ringing in the ears; ear infections; nose bleeds; sinus drainage; hay fever; hoarseness; difficulty swallowing; sore throat

**Respiratory/Lungs:** Wheezing; shortness of breath; frequent or chronic cough; coughing up blood

**Cardiovascular:** Chest pain; irregular/abnormal heartbeat; palpitations; high blood pressure; varicose veins; cramping in the legs; swelling of the feet/ankles; blood clots

**Gastrointestinal:** Nausea; vomiting; abdominal pain; indigestion; diarrhea/loose stools; constipation; blood in the stool

**Genitourinary:** Frequent urination; painful urination; excessive urination; bladder/kidney infections; kidney disease; bloody urine; testicular pain

**Neurologic:** Headaches; seizures; convulsions; tremors; sciatica; numbness in the arms or legs; loss of consciousness/blacking out; memory loss; dizziness; other

**Psychological/Emotional:** Nervousness; depression; sleep disorder or insomnia; mental illness

**Endocrine:** Hormone problems; thyroid disorder; heat or cold intolerance; diabetes; excessive thirst; swollen glands

**Hematologic/Lymphatic:** Easy bruising or excessive bleeding; anemia; lumps or bumps; lymphedema

**Other (not listed above):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please detail any other information you feel is important regarding your condition:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of patient, parent or guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of physician**

\_\_\_\_\_  
**Date**