

Please, answer ALL questions as complete as possible. Thanks.

Last Name

Maiden Name

First Name, Initial

Sex

☐ Male ☐ Female

Birthplace

Date of Birth

____|____|____

Age

Marital Status

☐ Single ☐ Widowed

☐ Married ☐ Divorced

Husband/Wife's Name

Local Address (City, State, Zip code, Country)

Permanent Address (City, State, Zip code, Country)

Home Phone Number

Permanent Phone Number

Social Security Number

____-____-____

Driver's License

Occupation

☐ Professional: ☐ Self-employed ☐ Employee ☐ Student ☐ Homemaker ☐ Retired
☐ Unemployed

Is this a Workers' Compensation Case ?

☐ Yes ☐ No

If yes, please provide: Insurance Company: _____

Adjusters Name : _____

Phone Number: _____

Case Number: _____

Is this a Litigation Case ?

☐ Yes ☐ No

If yes, please provide: Attorneys Name: _____

Phone Number: _____

Employer's Name

Employer's Address (City, State, Area Code)

Work Phone Number:

Race: (Mark only one)

☐ Caucasian ☐ Black ☐ Hispanic ☐ American Indian

☐ Other: _____

Religion: (Mark only one)

☐ Jewish ☐ Catholic ☐ Protestant ☐ Presbyterian

☐ Jehovah's witness ☐ Other: _____

NEXT OF KIN INFORMATION

Nearest Relative NOT LIVING WITH YOU

Relationship

Address (City, State, Zip code, Country)

Close Friend NOT LIVING WITH YOU

Friend's Phone Number

Referral information

☐ Primary Physician ☐ Other Physician ☐ University of Miami ☐ Jackson Memorial
☐ Attorney ☐ International Center ☐ Another Patient ☐ Yellow Pages ☐ Cedars

Referring Physician

Referring Physician's Phone Number

Primary Physician

Primary Physician's Phone Number

Primary Insurance

Policy Number

Secondary Insurance

Policy Number

If you are disabled, is the disability work related?

☐ Yes

☐ No

If you are unemployed, when was the last date you worked?

_____|_____|_____|

CURRENT PROBLEM

(Please fill in the circle on all that apply)

Shoulder: ☐ Left ☐ Right ☐ Both

INSTRUCTIONS TO ANSWER THE FOLLOWING TWO (2) QUESTIONS BELOW.

FOLLOW THE EXAMPLE.

If your answer is "3 months", your answer should be written as follows:

EXAMPLE: "3 MONTHS"=

0	3
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☐ Days ☐ Weeks ☐ Months ☐ Years

1. When did your pain begin?

--	--

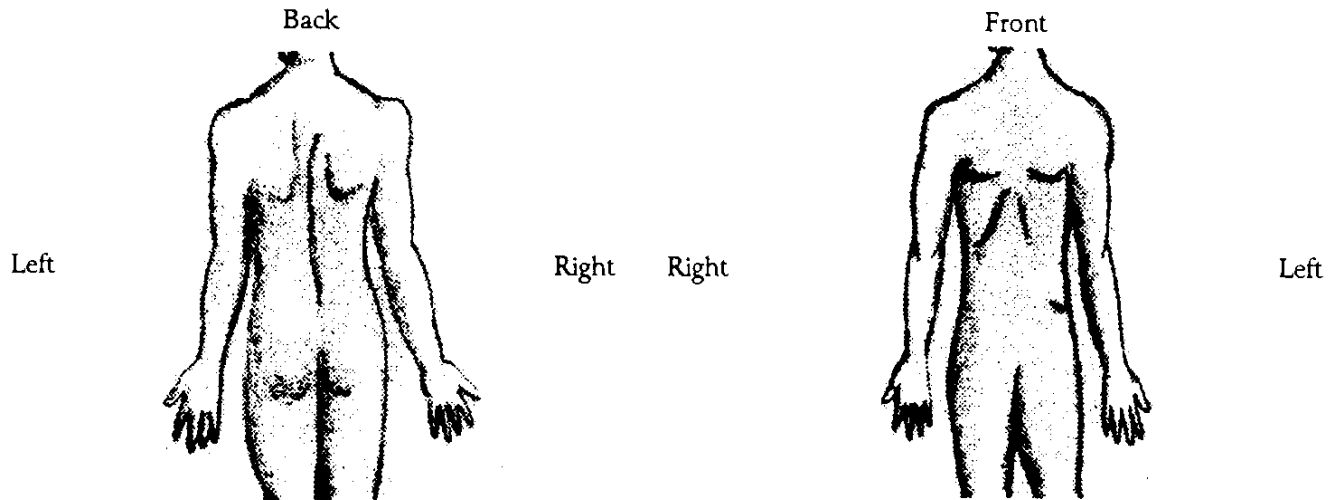
☐ Days ☐ Weeks ☐ Month ☐ Years

2. When did your current pain start getting worse?

--	--

☐ Days ☐ Weeks ☐ Months ☐ Years

Please mark with an X the representative areas on the diagram below where you feel pain.



For the next 2 questions: Place an X along the line in the area that best describes your sensation. When deciding your response for each question, please take into account the sensation asked on that question.

1. What is the intensity of the pain that you have most of the time?

dull _____ severe

2. How often do you have the pain described above?

almost never _____ always

Did your pain start because of: (fill the circle in all that apply)

- | | | |
|---------------------------------------|--------------------------------|------------------------------------|
| ☐ twisting injury | ☐ fracture | ☐ contusion |
| ☐ spontaneously | ☐ fall | ☐ car accident |

When did this occur? (Date of incident)

____ / ____ / ____

Do you feel any: (fill the circle in all that apply)

- | | |
|--------------------------------|--------------------------------------|
| ☐ pain | ☐ locking |
| ☐ swelling | ☐ loss of motion |
| ☐ weakness | ☐ aching |
| ☐ numbness | ☐ giving out |

How is your pain (most of the time)? ANSWER ONLY ONE

- ☐ None
- ☐ Mild or Occasional
- ☐ Only when using arm
- ☐ Moderate-Severe when using arm
- ☐ Severe even at night
- ☐ Intense and permanent
- ☐ Unable to do any activity

How is your pain at night? ANSWER ONLY ONE

- ☐ None ☐ Continuous ☐ Intermittent

How is the pain with no activity? ANSWER ONLY ONE

- ☐ None ☐ Mild ☐ Moderate ☐ Moderate-Severe ☐ Severe

SHOULDER: ANSWER ONLY ONE

Your shoulder pain is: (Mark only ONE in each column)

- ☐ So constant and unbearable that requires frequent use of strong medication
- ☐ Constant but bearable; occasional use of strong medication is required
- ☐ Present during light activities; none or little during rest; requires frequent use of salicylates
- ☐ Present during strenuous or particular activities only; requires occasional use of salicylates
- ☐ Occasional
- ☐ None

Due to the pain in your shoulder, you...

- ☐ Are unable to use that limb
- ☐ May use that limb for light activities only
- ☐ May use that limb for light housework and most activities of daily living
- ☐ May use that limb for most housework, shopping, driving, combing hair, dressing and undressing, including (if applicable) fastening brassiere
- ☐ Have a slight restriction only; and that limb may be used for work above shoulder level
- ☐ Are able to do normal activities

Symptoms Worsened by: (Mark ALL that apply)

- ☐ Resting
- ☐ Exercise
- ☐ Lifting heavy objects
- ☐ Carrying heavy objects

Symptoms Improved by: (Mark ALL that apply) ANSWER ONLY ONE

- ☐ Nothing
- ☐ Physical Therapy
- ☐ Ice
- ☐ Rest
- ☐ Exercise
- ☐ Medication

Activity Level: ANSWER ONLY ONE

- ☐ Require assistance for all activities
- ☐ Self care independent
- ☐ Indoor activities of daily living
- ☐ Outdoors activities of daily living

Which of the following statements best describes your work situation during the past month?
ANSWER ONLY ONE

- ☐ Working full-time
- ☐ Working part-time
- ☐ Unemployed because of my health
- ☐ Unemployed, looking for work
- ☐ Retired or quit work because of shoulder (or other joint) problems
- ☐ Retired for reasons unrelated to my shoulder (or affected joint)
- ☐ Homemaker, full-time o Student, full-time

How much does your shoulder or affected joint limit your ability to work?
ANSWER ONLY ONE

- ☐ No limitations
- ☐ Slightly limits me
- ☐ Moderately limits me
- ☐ Greatly limits me
- ☐ Totally limits me
- ☐ I am not working for reasons unrelated to my shoulder (or other joint problems)

How much does your shoulder (or other joint) limit or interfere with your sexual activity.
ANSWER ONLY ONE

- ☐ No limitations
- ☐ Slightly limits me
- ☐ Moderately limits me
- ☐ Greatly limits me
- ☐ Totally limits me
- ☐ I am not sexually active for reasons unrelated to my shoulder (or joint problem)

What one factor limits your activities the most? ANSWER ONLY ONE

- ☐ Nothing limits my activities
- ☐ Pain or limited motion in my LEFT SHOULDER
- ☐ Pain or limited motion in my RIGHT SHOULDER
- ☐ Pain in other area: _____
- ☐ Other health problem

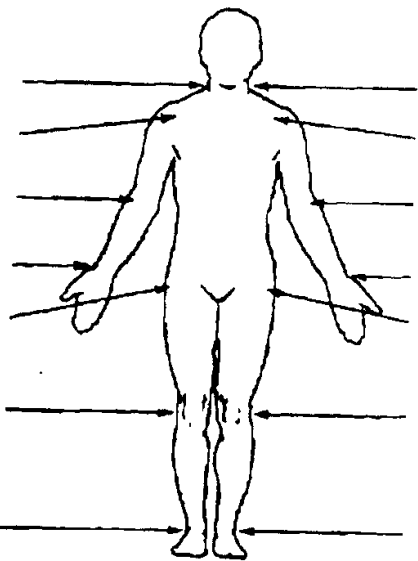
Overall, how limited are you in doing your usual activities? ANSWER ONLY ONE

- ☐ Not limited at all
- ☐ Slightly limited
- ☐ Moderately limited
- ☐ Greatly limited
- ☐ Totally limited

MARK THE CIRCLE of the additional areas where you feel pain at: (see the figures below)

RIGHT

- Neck ☐
- Shoulder ☐
- Elbow ☐
- Wrist ☐
- Hip ☐
- Knee ☐
- Ankle ☐

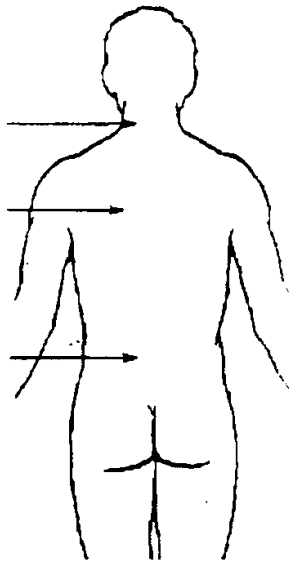


LEFT

- ☐ Neck
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hip
- ☐ Knee
- ☐ Ankle

BACK

- Neck ☐
- Upper Back ☐
- Lower Back ☐



Please mark with a “ C ” ALL medications that you are currently taking for this pain and with a “ P ” the ones you have taken in the past for this pain:

___ ASPIRIN	___ TYLENOL	___ TYLOX
___ PLAQUENIL	___ MECLOMEN	___ MOTRIN
___ CLINORIL	___ NAPROSYN	___ VOLTAREN
___ GOLD	___ FELDENE	___ ANSAID
___ BUTAZALIDIN	___ INDOCIN	___ RELAFEN
___ TOLECTIN	___ TRILISATE	___ DAYPRO
___ PREDNISONE	___ STEROIDS	___ DILAUDID
___ CODEINE	___ NAFLON	___ TALWIN
___ DARVON	___ MORPHINE	___ DEMEROL
___ PERCODAN	___ TYLENOL # 3	___ CELEBREX
___ ARTHROTEC	___ VIOXX	

Other anti-inflammatory or
analgesic drug not mentioned above _____

Have you taken STEROIDS in the past? ☐ Yes ☐ No

Name of steroid used: _____

Reason or medical condition for using steroids: _____

Dosage used: mg/day ...for ☐ weeks ☐ months ☐ years

TESTS that you have had done: (for your CURRENT PROBLEM)

- | | |
|------------------------------------|--|
| ☐ Plain X-rays | ☐ Arthrogram |
| ☐ Nerve Tests | ☐ Diagnostic Arthroscopy |
| ☐ C.A.T. Scan | ☐ M.R.I. |
| ☐ Bone Scan | ☐ Fluid Analysis |
| ☐ Blood Tests | ☐ Other _____ |

PREVIOUS JOINT INJECTIONS? ☐ Yes ☐ No

If Yes: ☐ Helpful ☐ Not helpful

Number of injections:

If helpful, for how long? ☐ days ☐ weeks ☐ months ☐ years

When was your LAST INJECTION? ☐ days ☐ weeks ☐ months ☐ years

Have you ever had PHYSICAL THERAPY? ☐ No ☐ Yes

If Yes: ☐ Helpful ☐ Not helpful

Prior Surgeries in your shoulders:

☐ Arthroscopy ☐ Replacement ☐ Fusion ☐ Other

If OTHER, please specify: 1. _____

Please, list other ORTHOPEDIC SURGEONS that you have seen:

Last, First Name: _____

Telephone No: () -- _____ STATE

COUNTRY: _____

Last, First Name: _____

Telephone No: () -- _____ STATE

COUNTRY: _____

Recommendation for surgery? ☐ For ☐ Against

What type of surgery was recommended?

Allergies: Please write the medication or food you are allergic to, in the appropriate spaces. Thank you.

- O Pollen 1. _____
- O Medicines: 2. _____
- O Food: 3. _____
- O Other: 4. _____
- O No known allergies 5. _____
6. _____

Please, list ALL the medications you are currently taking, the dosage and for how long have you been taking them:

EXAMPLE: 1. Coumadin 5 mg every day for 2 weeks
2. Percocet 1 tab every 6 hours for 7 days

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Social History / Housing

You live with: ☐ Wife/Husband

☐ Relatives

☐ Friends

☐ Nursing home

☐ Other: _____

You live in a: ☐ House

☐ Apartment

(If you live in an apartment;)

FLOOR NUMBER:

--	--

ELEVATOR ☐ Yes ☐ No

Are there any stairs? (in your house or apartment) ☐ Yes
☐ No

In case you need surgery, who will take care of you at home?

☐ My relatives

☐ My husband / wife

☐ My son / daughter

☐ Other: _____

Patient
Name: _____

Family History: Has anyone in your family had history of ...?

Condition / Disease

Relationship

Avascular necrosis (AVN)	☐ Yes	☐ No	☐ Do not know	_____
Cancer (CA)	☐ Yes	☐ No	☐ Do not know	_____
Diabetes (DM)	☐ Yes	☐ No	☐ Do not know	_____
Heart Disease (CAD)	☐ Yes	☐ No	☐ Do not know	_____
High Cholesterol	☐ Yes	☐ No	☐ Do not know	_____
Blood Clotting Disorders	☐ Yes	☐ No	☐ Do not know	_____
Hypertension/High Blood Pressure (HTN)	☐ Yes	☐ No	☐ Do not know	_____
Osteoarthritis (OA)	☐ Yes	☐ No	☐ Do not know	_____
Rheumatoid Arthritis (RA)	☐ Yes	☐ No	☐ Do not know	_____
Systemic Lupus Erythematosus (SLE)	☐ Yes	☐ No	☐ Do not know	_____

COMMENTS:

Habits:

Do you drink any CAFFEINATED BEVERAGES? (includes COFFEE, CHOCOLATE, TEA, SODAS, ETC...)

NOW: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

PAST: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

I drink about cups of coffee / tea daily

Do you drink any ALCOHOLIC BEVERAGES ? (include BEER, WINE, RUM, WHISKEY, ETC...)

NOW: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

PAST: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

Do you smoke or use TOBACCO in any form? (INHALED, CHEWED, ETC...)

NOW: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

PAST: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

GENERAL MEDICAL CONDITION:

Please, mark ALL THE BLANKS that apply, and explain if necessary:

Height

___ FT ___ IN

Weight

___ LBS

A. General Health

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

B. Head

- ☐ Headaches
- ☐ Past Injury

C. Neck

- ☐ Stiffness
- ☐ Pain
- ☐ Arthritis
- ☐ Thyroid trouble

D. Skin

- ☐ Infections
- ☐ Boils
- ☐ Psoriasis

E. Eyes

- ☐ Blindness: ☐ RIGHT ☐ LEFT ☐ BOTH
- ☐ Glasses or Contact Lenses
- ☐ Cataract ☐ RIGHT ☐ LEFT ☐ BOTH
- ☐ Pain

Patient

Name: _____

F.Ears

☐ Hearing loss: ☐ RIGHT ☐ LEFT ☐ BOTH

☐ Hearing aid

☐ Ringing/Buzzing

☐ Infection

☐ Other: _____

G. Nose and Throat

☐ Bleeding

☐ Hoarseness

☐ Polyps

☐ Sinus trouble

☐ Trouble swallowing

☐ Other: _____

H. Respiratory

☐ Asthma

☐ Wheezing

☐ Chronic cough

☐ Shortness of breath

☐ Coughing up blood

☐ Pain on breathing

☐ Other: _____

I. Heart

☐ Chest pain

☐ Heart disease (INFARCTS, ARRHYTHMIAS, DEFECTS, etc)

Date of event

☐ Leg cramps: (at night or while walking)

☐ Leg/ankle swelling

☐ Heartbeat: irregular or fast

☐ Blood pressure-High

☐ Blood pressure-Low

☐ Cold fingers/toes

☐ Sweating fingers/toes

☐ Other:

Patient

Name: _____

J. Bleeding

- ☐ Anemia
- ☐ Bleeding problems
- ☐ Other: _____

K. Stomach and Bowel

- ☐ Ulcer
- ☐ Loss of Appetite
- ☐ Swelling
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Colitis
- ☐ Nausea/Vomiting
- ☐ Pain
- ☐ Change in Bowel Habits
- ☐ Gallbladder problems
- ☐ Pancreatitis
- ☐ Other: _____

L. Urinary system

- ☐ Leakage
- ☐ Strong urine
- ☐ Pain on urination
- ☐ Back pain
- ☐ Sores on genitalia
- ☐ Discharge / drainage
- ☐ Bloody urine
- ☐ Frequent urination
- ☐ Night time urination
- ☐ Trouble (starting-stopping)
- ☐ Urinary infections
- ☐ Other:

M. Metabolic

- ☐ Diabetes
- ☐ Hypoglycemia (low blood sugar)
- ☐ Other: _____

N. Neurological System or Headaches

- ☐ Seizures (epilepsy)
- ☐ Paralysis
- ☐ Fainting
- ☐ Stroke:
- ☐ Numbness
- ☐ Other: _____

O. Psychological

- ☐ Nervous breakdown
- ☐ Crying frequently
- ☐ Tension
- ☐ Feeling BLUE
- ☐ Anxious
- ☐ Stress prone
- ☐ Cannot sleep
- ☐ Exhausted
- ☐ Other: _____

P. Prior Diseases or Infections

☐ Hepatitis

☐ Sexually transmitted: (Syphilis, AIDS, Herpes, Others...)

☐ Cancer: _____

☐ Infections: _____

Q. Female History

☐ Menopause

☐ Menstruating:

☐ Birth control pills:

☐ Intra uterine devices (IUDs)

R. Number of Pregnancies:

--	--

S. Number of Live Births:

--	--

T. Prior Surgeries: (Please, specify the date the procedure was done.)

- ☐ Neck fusion
- ☐ Back fusion
- ☐ Brain surgery
- ☐ Thyroid surgery
- ☐ Heart bypass surgery
- ☐ Bowel removal
- ☐ Kidney removal
- ☐ Hysterectomy
- ☐ Kidney stones
- ☐ Lumbar disc removal
- ☐ Chest surgery
- ☐ Cataract removal: ☐ LEFT ☐ RIGHT ☐ BOTH
- ☐ Stomach removal
- ☐ Colostomy
- ☐ Gallbladder removal
- ☐ Caesarian section
- ☐ Appendectomy
- ☐ Prostate Removal
- ☐ Balloon angioplasty
- ☐ Bladder repair
- ☐ Hemorrhoidectomy
- ☐ Tubal ligation
- ☐ Vascular surgery
- ☐ Vein ligation / stripping
- ☐ Inguinal Hernia repair: ☐ LEFT ☐ RIGHT ☐ BOTH
- ☐ Other:

1. _____
2. _____
3. _____