• Kevin P. Hanlon, D.O.

SHOULDER HISTORY

• James L. Kehoe, D.O.

Name _____ Date ____ /____ /____

Highest year of school completed _____ Age_____ ☐Male ☐Female Ht. _____ Wt. _____

Currently Working? ☐Yes ☐No ☐Retired If yes, type of work _____

PRESENT COMPLAINT: (check one) ☐**RIGHT SHOULDER** ☐**LEFT SHOULDER**

Please describe the problem: _____

Is present problem related to Injury? ☐Yes ☐No If yes, when _____

Where? ☐Athletics ☐At Work ☐Home ☐School ☐Vehicle ☐Other: _____

Do you have pain: ☐Yes ☐No If yes, grade your pain: 1 2 3 4 5 (1= minor 5 = Severe)

Describe your pain: _____

Locate your pain: ☐ **RIGHT SHOULDER** ☐Front ☐Back ☐Armpit ☐Upper arm ☐Neck ☐Radiating

☐ **LEFT SHOULDER** ☐Front ☐Back ☐Armpit ☐Upper arm ☐Neck ☐Radiating

Is your pain *increased* by: ☐Lifting ☐Reaching ☐Pulling ☐Pushing ☐Other _____

Is your pain *decreased* by: ☐Position changes ☐Exercise ☐Medications ☐Phys. Therapy ☐Other _____

Have you had any of the following?

	RIGHT SHOULDER		**LEFT SHOULDER**	
Dislocating	☐Yes	☐No	☐Yes	☐No
Swelling	☐Yes	☐No	☐Yes	☐No
Locking	☐Yes	☐No	☐Yes	☐No
Clicking / Popping	☐Yes	☐No	☐Yes	☐No
Grating / Grinding	☐Yes	☐No	☐Yes	☐No
Night Pain	☐Yes	☐No	☐Yes	☐No

Are you able to:

Walk	☐Yes	☐No	☐Full time	☐Part time
Play Sports	☐Yes	☐No		
Reach	☐Yes	☐No		
Dress	☐Yes	☐No		

Have you been previously treated ? ☐Yes ☐No

If yes, when _____ Where _____

Do you have: ☐Rest ☐Ice/Heat ☐Sling ☐Injections ☐Therapy ☐X-Rays ☐Surgery ☐Other: _____

Comments: _____

Have you had previous problems? ☐Yes ☐No **RIGHT SHOULDER** **LEFT SHOULDER**

If yes, when? _____ _____

Describe: _____

From Injury? ☐Yes ☐No If yes, where: ☐Athletics ☐At work ☐Home ☐School ☐Vehicle ☐Other: _____

How was this **previous** problem treated?

	RIGHT SHOULDER		**LEFT SHOULDER**		**DATES**
Rest	☐Yes	☐No	☐Yes	☐No	_____
Physical therapy	☐Yes	☐No	☐Yes	☐No	_____
Injections	☐Yes	☐No	☐Yes	☐No	_____
Arthroscopy	☐Yes	☐No	☐Yes	☐No	_____
Open Surgery	☐Yes	☐No	☐Yes	☐No	_____

Comments: _____

Do you have: ☐Other Joint Problems ☐Urinary Infection ☐Fever ☐Chills ☐Rheumatoid or other Arthritis

☐Family history of arthritis ☐Other Health Problems: _____

Any additional important information: _____

Rev. 6/04 _____