BECKER ORTHOPEDICS

Advanced skills and experience for the results you deserve

PATIENT INFORMATION SHEET

Shoulder

RIGHT LEFT

Name: _____

Date:_____

Please give a brief description of your symptoms/problems. (Where and how does it hurt)

_____

_____

_____

When did this start?
(approximate date or number of days, weeks, months, years)

_____

How did this happen? Were you injured?

_____

History of fracture? **Yes** **No**

History of dislocation? **Yes** **No**

History of other injury? _____

History of arthritis **Yes** **No**

Have you had any cortisone injection into your shoulder? **Yes** **No**

If yes, which shoulder? **Right** **Left**

Have you had any surgery on your shoulder?

If yes, when?_____

Type of operation, if known_____

Have you had any of these examinations done to your shoulder?

X-rays? **Where?**_____**When?**_____
Arthrogram? **Where?**_____**When?**_____
CT? **Where?**_____**When?**_____
Ultrasound? **Where?**_____**When?**_____
MRI? **Where?**_____**When?**_____