



**James M. Farmer M.D.**  
**New Patient Medical History for SHOULDER Symptoms**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Phone number: \_\_\_\_\_

Referred by: \_\_\_\_\_ Date of Injury/Onset of symptoms: \_\_\_\_\_

**Reason for visit.** Describe injury or onset in detail:  LEFT  RIGHT \_\_\_\_\_

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

**Pain:**  Sharp  Dull  Stabbing  Burning  Other: \_\_\_\_\_

Constant  Intermittent **Intensity:** 0—1—2—3—4—5—6—7—8—9—10

**Location (describe):** \_\_\_\_\_

**Does the pain go anywhere else (describe)?** \_\_\_\_\_

**What makes pain worse?**  Pushing  Pulling  Reaching Overhead  Across body  Behind back

Sleeping  Driving  Throwing  Lifting Weights  Other: \_\_\_\_\_

**What makes pain better?**  Rest  Activity Modification  Ice/Heat  Meds

Other: \_\_\_\_\_

**What other symptoms are present?**  Catching  Popping  Grinding  Locking  Dislocation

Subluxation  Swelling ( constant  fluctuates)

**What treatments have you attempted and what effect?** (PT, meds, injections) \_\_\_\_\_

**Can you work or participate in sports with current symptom?**  NO  YES

**Do you have light duty available at work?**  NO  YES

**Past Medical and Family History** (check all that apply  You  Family History)

High Blood Pressure   Heart Disease   Stroke   Diabetes

COPD   Asthma   Reflux   Ulcers

Kidney Disease   Vascular Disease   Hepatitis   Blood Clots

Bleeding Disorder   Cancer   Arthritis   Seizures

Headaches   HIV

Other: \_\_\_\_\_

**Past Surgical History**  (check all that apply)

Appendectomy  Gall Bladder  Hernia  Breast

Heart Bypass  Heart Valve  Pacemaker  Spine/Neck

Arthroscopy  Joint Replacement  Rotator Cuff  Hysterectomy

Other: \_\_\_\_\_

**Drug Allergies** (list all known drug allergies)

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

**Medications:** (please list all prescription and over the counter medications and supplements)

Separate List Attached

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

**Social History**

Single     Married     Divorced     Widowed    Children?  NO  YES # \_\_\_\_\_

Do you smoke?  NO  YES \_\_\_\_\_ packs per day

Do you drink alcohol?  NO  YES    Do you use drugs?  NO  YES (list) \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Do you exercise regularly?  NO  Yes    \_\_\_\_\_ days per week

Do you participate in sports?  NO  YES (list) \_\_\_\_\_

**Review of Systems**

Do you currently or frequently have:  (check all that apply)

**Constitutional**

- Weight loss
- Weight gain
- Fever
- Chills

**Eyes**

- Blurred vision
- Double vision

**Ears, Nose, Throat**

- Hearing loss
- Ringing in ears
- Congestion
- Sore throat

**Respiratory**

- Shortness of breath
- Wheezing
- Cough
- Coughing blood

**Cardiovascular**

- Chest pain
- Palpitations

**Genitourinary**

- Painful urination
- Blood in urine
- Urgency/frequency
- Incontinence

**Gastrointestinal**

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Incontinence

**Skin**

- Rash
- Skin lesion
- Nail problems

**Neurological**

- Headaches
- Seizures
- Dizziness
- Balance problems
- Numbness/tingling
- Weakness

**Endocrine**

- Thirst
- Tired/sluggish
- Hot
- Cold

**Hematologic**

- Bleeding problems
- Bruising
- Limb swelling

**Psychiatric**

- Depression
- Anxiety
- Insomnia
- Addiction
- Drug use

**Musculoskeletal (other than current complaint)**

Joint pain (list) \_\_\_\_\_  
\_\_\_\_\_

- Back pain
- Neck pain
- Joint stiffness
- Joint swelling
- Gout

**Other Medical**

**Concerns: (list)**

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

**Height:** \_\_\_\_\_

**Weight:** \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

