Gavin Orthopaedics, LLC

MOSS CREEK ORTHOPAEDIC URGENT CARE
Scrapes • Sprains • Shots • Stitches

Initial Visit Shoulder

Date:_____

Age:_____

Patient Name: _____

Date of Birth _____

Referring Physician: _____ Primary Physician _____

Problem with: ☐ Right Shoulder ☐ Left Shoulder Estimated date first noticed problems: _____/_____/_____

Was this due to injury? ☐ Yes ☐ No Was injury work related? ☐ Yes ☐ No

Currently working? ☐ Yes ☐ No How did injury occur :_____

Prior surgery for this problem? ☐ Yes ☐ No If yes, list date, procedure and doctor _____

How would you rate your worst pain? ☐ 1 (No pain), ☐ 2, ☐ 3, ☐ 4, ☐ 5, ☐ 6, ☐ 7, ☐ 8, ☐ 9 and ☐ 10 (severe pain)

Problem is presently: ☐ Worsening ☐ Unchanged ☐ Improving

The pain is? ☐ Constant ☐ Intermittent

Location? ☐ Upper Arm ☐ Below Elbow ☐ Neck ☐ Front Shoulder
☐ Back Shoulder ☐ Outside Shoulder ☐ Top Shoulder

Quality? ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing
☐ Tingling ☐ Electric Shocks

Other Complaints? ☐ Locking ☐ Giving way ☐ Night Pain
☐ Stiffness ☐ Swelling ☐ Weakness

Activities which were interfered with include:

☐ Sports ☐ Shopping ☐ Sleeping
☐ Running ☐ Gardening ☐ Working ☐ Other_____

When do Symptoms occur?: ☐ Night ☐ Morning ☐ At Work ☐ During Exercise ☐ After Exercise
☐ Putting on shirt/coat ☐ Throwing a ball

Treatments that have been tried include:

☐ Anti Inflammatory_____	☐ Helped?	☐ Not Helped	☐ Physical Therapy	☐ Helped?	☐ Not Helped
☐ Pain Medications _____	☐ Helped?	☐ Not Helped	☐ Sling	☐ Helped?	☐ Not Helped
☐ Exercises	☐ Helped?	☐ Not Helped	☐ Other_____	☐ Helped?	☐ Not Helped
☐ Reduced Activity	☐ Helped?	☐ Not Helped	☐ MRI		
☐ Injections	☐ Helped?	☐ Not Helped	☐ X-ray		

Review of Systems: Please check all that apply for you

☐ Chest Pain	☐ Hypertension	☐ Parkinson's Disease	☐ Sickle Cell Disease
☐ Heart Murmer	☐ Leukemia	☐ Liver Disease	☐ Thalassemia/Von Willebrands
☐ Heart Attack	☐ Emphysema/Chronic Bronchi	☐ Hearing Loss	☐ Hemophilia
☐ Heart Valve Disease	☐ Kidney Failure	☐ Poor Vision	☐ Stomach Ulcer/Reflux
☐ Irregular Heart Beat	☐ Kidney Stones	☐ Cataracts	☐ Ulcerative Colitis/Chron's
☐ Pacemaker	☐ Prostate Disease	☐ Depression/Bipolar Disorder	☐ Hepatitis
☐ Stroke	☐ Incontinence	☐ Schizophrenia	☐ Psoriasis or Skin Disease
☐ TIA	☐ Seizure	☐ Thyroid Disease	☐ HIV
☐ Asthma/Tuberculosis	☐ Multiple Sclerosis	☐ Adrenal/Pituitary Disease	☐ COPD

☐☐ Diabetes, controlled with: Insulin Oral Medication Diet
☐☐ Cancer, which type/where?_____ Treatment_____
☐☐ None of the above _____ ☐☐ Other_____
☐☐ **SECOND OPINION**_____

Family History	Yes?	Relationship	Family History	Yes?	Relationship
Arthritis (Specify type)			High Blood Pressure		
Bleeding Problems			Congenital Heart Disease		
Cancer (Specify)			Leukemia		
Diabetes			Liver Disease		
Emotional Problems			Stroke		
Epilepsy/Seizures			Suicide		
Heart Disease			Tuberculosis		