ORTHOMO
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Husam Nawas, M.D
Orthopedic Sports Medicine
Hip Arthroscopy & Preservation
Minimally Invasive Joint Replacement

NEW PATIENT SHOULDER INTAKE FORM

Name: _____ **Age:** _____ **Date of Birth:** _____

Best Contact Number: _____ **Email Address:** _____

Primary Care Physician and Phone Number: _____

Preferred Pharmacy and Phone Number: _____

Who referred you to Dr. Nawas? _____

Goal for Today's Visit _____

Height: _____ **Weight:** _____

Which Extremity? ☐ Right ☐ Left ☐ Both

How long have you had pain? _____

Trauma/Injury: Was there an injury or event that started the pain? If so, explain:

_____

Onset (Circle): Gradual OR Sudden **Timing (Circle):** Constant OR Intermittent

Pain: On a scale of 1-10, 10 being worst pain imaginable:

- What is your pain at rest? _____
- What is your pain with activity? _____

Location: Where is your shoulder pain located? (Front, Back, Outside)

Explain: _____

Describe: How would you describe your shoulder pain? (Aching, Dull, Burning, Throbbing, Sharp, Tight, Tingling)

Explain: _____

Mechanical Issues: Do you have any of the following symptoms with your shoulder? (Locking, clicking, or catching)

Explain: _____

Associated symptoms: ☐ Stiffness ☐ Swelling ☐ Decreased Mobility ☐ Dislocation

Do you have pain at night? YES OR NO **Does this shoulder pain wake you at night?** YES OR NO

Exacerbation: What makes your pain worse? ☐ Nothing ☐ Activity ☐ Overhead Activity ☐ Reaching ☐ Lifting ☐ Sports ☐ Other: _____

Alleviation: What makes your pain better? ☐ Nothing ☐ Rest ☐ Heat ☐ Ice ☐ Massage ☐ NSAIDS (Ibuprofen, Aleve) ☐ Tylenol ☐ Topical creams ☐ Other: _____

Previous Treatments: Have you tried any of the following?

- ☐ NSAIDS (Aleve, Ibuprofen, Mobic, meloxicam) For how long? _____
- ☐ Opioids (Hydrocodone, Percocet) For how long? _____
- ☐ Steroid Injections How many? _____
- ☐ Physical Therapy or Home Exercise Program For how long? _____
- ☐ Joint support (Brace, Cane, Crutches, Walker, Scooter) Explain: _____
- ☐ Tylenol ☐ Muscle Relaxant ☐ Glucosamine ☐ Pain Management ☐ Chiropractor
- ☐ Other Explain: _____

Neurological Complaints: Do you have any of the following?

☐ Numbness ☐ Tingling ☐ Weakness ☐ Leg Pain ☐ None

Previous Imaging on your shoulder: _____

Past Medical History: Have you had any of the following? **(Circle all that apply)**

Anemia	Emphysema (COPD)	Osteoporosis
Arthritis (Rheumatoid)	GERD / Reflux	Seizure / Epilepsy
Arthritis (Osteoarthritis)	Gout	Stomach ulcer
Asthma	Heart disease	Stroke
Blood clots	Hepatitis	Thyroid (high or low)
Cancer _____	High blood pressure	_____
Depression	High cholesterol	_____
Diabetes	Kidney disease	_____

Past Surgical History (Including shoulder surgeries and year) _____

_____

Allergies and Reaction:

_____

List All Current Medications With Dosage:

_____

_____

_____

Nicotine use? Yes OR No Frequency _____ **Alcohol use:** Yes OR No Frequency _____

Occupation: _____ **Work Related Injury (Circle):** YES OR NO

Are you a student? Where? _____ **Sports?** _____

Coach/Athletic Trainer Name: _____

Physical/Recreational Hobbies: _____

Name: _____ Date of Birth: _____

Review of Systems Checklist

Are you currently Experiencing any of the following? (Check all that apply, please)

Fever	☐	Cough	☐
Chills	☐	Coughing up blood	☐
Sweats	☐	Shortness of Breath	☐
Fatigue	☐	Chest pain with breathing/coughing	☐
Weight loss	☐	Wheezing	☐
Weight gain	☐		
Blurry vision	☐	Swollen lymph nodes	☐
Decreased vision	☐	Bleeding	☐
Loss of vision	☐	Bruising	☐
Eye pain	☐		
Double vision	☐	Abdominal pian	☐
Sensitivity to light	☐	Back pain	☐
Discharge from eyes	☐	Nausea	☐
		Vomiting	☐
Sore throat	☐	Diarrhea	☐
Nasal congestion	☐	Constipation	☐
Nasal discharge	☐		
Black or bloody stool	☐		
Nose bleeds	☐		
Ringing in ear	☐	Dizziness or vertigo	☐
Hearing loss	☐	Headache	☐
		Weakness	☐
Chest pain	☐	Numbness or tingling	☐
Shortness of breath with activity	☐	Problems with your speech	☐
Shortness of breath at rest	☐	Confusion	☐
Loss of consciousness	☐	Memory loss	☐
Severe shortness of breath and coughing at night	☐	Rash	☐
Swelling in the arms or legs	☐	Itching	☐
Abnormal heartbeat	☐	Hives	☐