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FOR OFFICE USE
 Transcribed

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INITIAL SHOULDER CONSULTATION

NAME: _____ AGE: _____ DATE: _____

SEX: MALE FEMALE HAND DOMINANCE: RIGHT LEFT

HEIGHT: _____ WEIGHT: _____ SOCIAL SECURITY NO: ____ - ____ - ____

INSURANCE: _____ POLICY NO: _____

REFERRED BY: _____ PHONE NO: _____

HOSPITAL/ ADDRESS: _____

Which Shoulder: Right Left

Date of onset OR length of symptoms: _____

Prior injuries to this shoulder: YES NO

If yes, please describe: _____

Please describe how your symptoms began (traumatic/injury OR gradual/unknown onset):

If 100% were normal, as of today what percentage would you give your shoulder as a grade? _____

Pain at rest (1 least - 10 greatest) _____

Pain with activity (scale 1-10) _____

Pain with overhead activities: YES NO

Pain at night: YES NO

Activities that make the pain better:

Activities that make the pain worse:

Type of Pain: Sharp Dull Throbbing Numbness

Shooting Burning Tingling

Nature of Pain: Constant Frequent Occasional Intermittent

Since onset, is the pain getting: Better Worse

Does the pain radiate? Yes No

If yes, to where: Neck Arm Hand

Symptoms are worse in: Morning Afternoon Night Same all day

Any mechanical symptoms: None Popping Clicking Instability

Any neck pain: Yes No

In your hand, do you have any of the following: Numbness Tingling Weakness

Have you seen anyone for this problem Yes No
If yes, who: Family doctor Orthopaedic Surgeon Therapist Other
Name, Location, Phone _____
Type of Treatment _____

Did your symptoms improve after: Yes No
Please describe: _____

Please describe your hobbies/ activities/ sports: _____

REVIEW OF SYSTEMS

HEENT (Head, Ears, Eyes, Nose, and Throat):

- Normal Headaches Glaucoma
 Cataracts Dental Problems Sinusitis

PULMONARY (Lungs):

- Normal Asthma COPD
 Shortness of Breath

CARDIOVASCULAR (Heart):

- Normal Chest Pain Palpitations
 Previous Heart Surgery Abnormal rhythm

NEUROLOGIC:

- Normal Stroke Seizure
 Motor/Sensory Deficit Headaches

GASTROINTESTINAL:

- Normal Stomach pain with NSAIDs (Motrin, Ibuprofen)
 Ulcer Heartburn
 GI/Rectal Bleed Adverse reaction to NSAIDs

GENITOURINARY:

- Normal Frequent night-time urination Prostate
 Burning with urination Incontinence

SKIN:

- Normal Skin rash Psoriasis

MUSCULOSKELETAL

- Normal except shoulder Other joint pains: location _____

PAST MEDICAL HISTORY

Please list any Medical Illnesses (i.e. diabetes, high blood pressure, etc...)

1. _____ 2. _____
3. _____ 4. _____

List any prior surgeries

Type of Surgery	Year	Hospital – Surgeon
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

List any allergies to medications

Medication	Side Effect
1. _____	
2. _____	
3. _____	

List current medications being taken on a regular basis (include dose and how often)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

FAMILY HISTORY

Father Living Any medical problems: _____
 Deceased – at age _____ Cause: _____
Mother Living Any medical problems: _____
 Deceased – at age _____ Cause: _____
Siblings: Number _____ Any medical problems: _____

SOCIAL HISTORY

Marital Status: Married Single Divorced
Number of children: _____
Do you smoke? No Yes – If so how many packs per day: _____
Do you drink alcohol? No Occasionally Daily

Employment

Type of work: _____
Currently working: Yes No
If not working:
Are you temporarily unemployed off work – how long _____
Any heavy lifting involved with work: Yes No

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Signature of Patient or Parent of Minor Date Reviewed by MD (physician signature)

SHOULDER MUSCULOSKELETAL EXAM (TO BE COMPLETED BY M.D.)

CONSTITUTIONAL

General Appearance of the patient

- Normal (WD/WN)
- Abnormal _____

PSYCHIATRIC

- Normal (Alert/Oriented x 3)
- Abnormal _____

HEENT

- Normal (AT/NC, EOMI)
- Abnormal _____

LYMPHATIC

- Normal (no lymphadenopathy)
- Abnormal _____

SKIN

- Normal (no ulcers/ lesion, incisions as described in Extremity exam)
- Abnormal _____

CARDIOVASCULAR

Peripheral vascular system

- Observation: Normal Swelling Varicosities
- Palpation: Pulses DP 1+ 2+ non-palp
- PT 1+ 2+ non-palp
- Temperature warm cool
- Edema none 1+ 2+ pitting

NEUROLOGIC

Deep tendon reflexes

- Biceps 1+ 2+ hyper-reflexic absent
- Brachioradialis 1+ 2+ hyper-reflexic absent
- Triceps 1+ 2+ hyper-reflexic absent

Sensation

- Normal Abnormal _____

CERVICAL SPINE

- Normal (FROM, supple, no midline TTP)
- TTP: none Paraspinal Bony over C___
- Decreased/ painful ROM with,
 - side bending flexion extension

RIGHT UPPER EXTREMITY

- Inspection: normal arthroscopy incision
 - arthroscopy incisions
 - atrophy: _____
- Palpation: Normal
 - TTP AC joint SC joint
 - Anterior capsular area
 - Posterior capsular area
 - Arthroscopy portals
 - Other: _____
- ROM: full (Forward elevation 180/180, ER 80/80, IR T7/T7)
 - Active / Passive
 - FF _____ / _____ Supine
 - ER _____ / _____ Sitting
 - IR _____ / _____ Standing
- Stability:
 - Anterior drawer Negative 1+ 2+ 3+
 - Posterior drawer Negative 1+ 2+ Severe
 - Anterior Apprehension Negative Positive
 - Jobe relocation test Negative Positive
 - Sulcus sign No sag Mild Sag Mod Sag Severe Sag
 - Load and shift Negative Painful Clunking
 - Jerk test Negative Discomfort
 - Subluxates Dislocates
 - Kim test Negative Painful
 - Position of Instability _____
 - Other: _____
- Muscle Strength normal abnormal _____
- Muscle Tone normal abnormal _____
- Other / Special Tests
 - Resisted abduction Negative Painful Weak
 - Resisted ER Negative Painful Weak
 - Speed's test Negative Painful
 - Yerguson's test Negative Painful
 - O'Brien's test Negative Painful
 - Neer's Test Negative Painful
 - Hawkin's Test Negative Painful
 - Lift off test Negative Weak
 - Belly press Negative Weak
 - Horizontal Adduction Negative Painful
 - Other: _____
- Scapula
 - Winging No Yes
 - Synchrony of Motion Yes No
 - Atrophy No Yes
- Other: _____

LEFT UPPER EXTREMITY

- Inspection: normal arthroscopy incision
 - arthroscopy incisions
 - atrophy: _____
- Palpation: Normal
 - TTP AC joint SC joint
 - Anterior capsular area
 - Posterior capsular area
 - Arthroscopy portals
 - Other: _____
- ROM: full (Forward elevation 180/180, ER 80/80, IR T7/T7)
 - Active / Passive
 - FF _____ / _____ Supine
 - ER _____ / _____ Sitting
 - IR _____ / _____ Standing
- Stability:
 - Anterior drawer Negative 1+ 2+ 3+
 - Posterior drawer Negative 1+ 2+ Severe
 - Anterior Apprehension Negative Positive
 - Jobe relocation test Negative Positive
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 - Horizontal Adduction Negative Painful
 - Other: _____
- Scapula
 - Winging No Yes
 - Synchrony of Motion Yes No
 - Atrophy No Yes
- Other: _____