BaylorScott&White
THE SHOULDER CENTER
AT BAYLOR UNIVERSITY MEDICAL CENTER AT DALLAS
A member of HealthTexas Provider Network

Date:_____**Name:** _____ **Date of Birth:**_____ **Are you flying in for this apt:**
Age: _____ **Hand Dominance**: R L A **Sex**: M F **Occupation:**_____ Height: _____ft ____ in
Chief Complaint:_____ Weight: _____ lbs
Referring Doctor/Person:_____ **Primary Care Doctor**_____

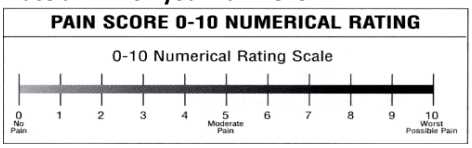
Have you seen another orthopedic surgeon:_____

History of Present Illness

What is the history of your shoulder problem(s)?

_____
_____
_____
_____
_____
_____
_____
_____

Symptoms:
Place an "X" on your Pain Level:



How would you rate your shoulder from 0-100%? (With 100% being normal)?_____

Do you have pain at night? Y N Can you sleep on your shoulder? Y N
Where is the pain located? □ Front □ Back □ Side □ Top □ Neck □ Arm/Hand □ Other:_____
Do you have numbness/tingling? Y N Location?_____ _____Does your shoulder feel unstable? Y N
Do you have the following? □ popping □ grinding □ catching □ locking
Can you lift your arm above shoulder level? Yes No
Have you ever had cervical issues or cervical surgery? Yes No _____

Have you had any of the following?
□ Injections? How many?_____Who gave it?_____ Relief after injection? □ none □ 25% □ 50% □ 75% □ 100%
□ Medications? What?_____Relief after meds? □ none □ 25% □ 50% □ 75% □ 100%
□ Physical therapy? How long?_____ Where?_____ Relief after PT? □ none □ 25% □ 50% □ 75% □ 100%

What radiology procedures have you had on your shoulder(s)?

Date(s)	Procedure	Result

What surgeries have you had on your shoulder(s)?

Date(s)	Procedure	Surgeon	Result

Allergies to Meds or other substances (include reaction):

_____
_____
_____

Date:_____Name: _____ _____ Date of Birth:_____

MEDICAL HISTORY: PCP _____ Last Seen _____ Last Labs _____

	YOU	FAMILY
Heart Disease	If yes, what type? Who is your cardiologist?	
Diabetes	If yes, last Hemoglobin A1c?	
Thyroid problems **Low or High**	If yes, when was the last time the dosage of your thyroid medication changed?	
Cancer	If yes, what kind? When? When was your last PET scan?	
High Cholesterol		
Reflux		
Rheumatoid Arthritis	When/how were you diagnosed? Who is your rheumatologist?	
Seizures/epilepsy	If yes, when was your last seizure? Did anyone witness it? Who is your neurologist?	
Menopause (females) **Vitamin D Level** **Testosterone level**	When? **High or Low**	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

1. Do you have a pain management doctor? YES NO

   If yes, what is the doctor's name?_____
   Do you have a pain pump? YES NO

2. Do you take any blood thinners (ex: Plavix, Coumadin, etc.)? YES NO

   If yes, which one?_____Diagnosis?_____

3. Do you have any upcoming surgeries planned? YES NO

   If yes, what type?_____When?_____

4. Have you had any type of surgery in the last 6 months? YES NO

   If yes, what kind?_____When?_____

5. Have you had any recent dental procedures, or do you have any scheduled? YES NO

   If yes, what type?_____When?_____

6. Have any of your family members had surgery with Dr. Krishnan? YES NO

   If yes, who are they?_____